



Overview of Medications at Fountainhead Montessori

Fountainhead only administers medications for medically necessary situations as determined on a case by case review.

For Fountainhead to dispense medication the following is required:

- A. Medication must have a doctor or pharmacy label. It must be clearly labeled with the child's name and dosage.
- B. Written instructions from the physician on symptoms and steps to be taken in the event the medication needs to be used. Written instructions must include any use of an over the counter medication, i.e. Benadryl.
- C. Over the counter medication must be within its stated expiration date and still sealed in its original container.
- D. Medications must stay on campus for at school use only. Please do not take the medication home, except if it has expired or needs to be replaced. This will ensure the medication is on hand in case it needs to be used.

Required State and Fountainhead Forms for dispensing any medication:

1. Fountainhead Montessori School Release and Authorization
2. Parent Consent For Administration of Medications and Medication Chart (LIC 9221)
This form keeps a record of who administers the medication, when, and what dose.
3. Written instructions from the physician (see part B above).

Additional forms required for ANY inhaled medication, not just nebulizers:

4. Nebulizer Care Consent/Verification (LIC 9166). This form is completed for each person (teacher, assistant, Child Care staff) that would possibly administer the medication.

Please submit all items in a zip-lock bag labeled with your child's name. Give the medication to your child's head teacher or campus site director. Please include a small picture of your child in the zip lock bag, this is an excellent safety measure. These items are kept in a locked medical box. Furthermore, your campus Site Director verifies paperwork, medications, and signs the paperwork as well. Failure to provide any portion of the required documentation may result in Fountainhead not accepting your medication on campus.

Fountainhead Montessori School

6665 Amador Plaza Road Ste. # 200 Dublin CA 94568

Locations in Danville, Dublin, Livermore, Orinda, and Pleasant Hill

Phone: 925.820.1343 Fax: 925.820.9193 Email: info@fms.org Web: www.fms.org



RELEASE AND AUTHORIZATION

THIS IS A RELEASE, WRITTEN AUTHORIZATION AND WAIVER OF LIABILITY FOR ADMINISTERING _____ TO _____ between
(Medicine Name) (Child's Name)

Fountainhead, Inc., a California Nonprofit Corporation, and its officers, employees and agents (collectively referred to as "Fountainhead") and _____ the parents and legal guardian of _____ have
(Parent's Name's) (Child's Name) (Parent's Name's)

requested Fountainhead provide _____ medication to _____
(Medicine Name) (Child's Name)

while attending Fountainhead, Inc.'s Montessori School located at _____, California, and
(City campus is located in)

to take certain actions described in the physician's instructions which are attached to this Release and are hereby incorporated by reference.

The parties agree that _____ authorize and instruct
(Parent's Name's)

Fountainhead to administer _____ medication to _____
(Medicine Name) (Child's Name)

_____ while at Fountainhead Montessori Schools, _____ Campus.
(City campus is located in)

_____ further authorize Fountainhead to contact Dr.
(Parent's Name's)

_____, _____ health care provider, and to rely on all verbal
(Doctor's Name) (Child's Name)

and written instructions given by such physician to Fountainhead. _____ shall
(Parent's Name's)

provide Fountainhead with written instructions as attached hereto as Exhibit A from _____ physician complying with the requirements of Health and Safety Code Section
(Child's Name)

1596.798(a)(2) (the "Instructions"), or any other applicable statutes or regulations.

_____ on behalf of themselves and _____ release
(Parent's Name's) (Child's Name)

Fountainhead and its officers, employees or agents from all liability which may arise as a result of Fountainhead, Inc.'s administering _____ medication or following the
(Medicine Name)

directions in the Instructions (including any additional physician's instructions or clarifications).

_____ also release Fountainhead and its officers, employees or
(Parent's Name's)

agents from all liability arising out of the use of any materials and/or equipment supplied by _____ in connection with the _____ treatment described
(Parent's Name) (Medical Condition)

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herein as long as such officers, employees or agents exercise reasonable care in the use of such materials or equipment. _____ acknowledges that he/she/they have had
(Parent's Name's)
an adequate opportunity to consult with their physician, and any other advisors of their choice before entering into this Release Agreement. The undersigned understand that Fountainhead would not provide the requested medication without the Release set forth in this document.

To the extent allowed by law, Fountainhead is released from any and all liability relating to the subject matter of this Release, Authorization and Waiver, and shall be held harmless, and fully indemnified, by the undersigned with respect to any claim relating to the administration of medication or following the directions in the Instructions as described herein. This hold harmless and indemnification shall include any costs and attorney's fees associated with any claim relating to the matters set forth herein.

This Release shall be governed by the laws of the State of California.

Dated: _____

FOUNTAINHEAD, INC.
A California Nonprofit Corporation

By: _____

By: _____

Dated: _____

Signature of Parent or Guardian
Telephone No: _____
Address: _____

Dated: _____

Signature of Parent or Guardian
Telephone No: _____
Address: _____

PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: Regulation Section 101221 requires the following information be on file.

| | | |
|-------------------------|-----------------|-------|
| CHILD CARE CENTER NAME: | LICENSE NUMBER: | DATE: |
|-------------------------|-----------------|-------|

PARENT'S INSTRUCTIONS:

1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

| | |
|-----------------|---------------|
| CHILD'S NAME | DATE OF BIRTH |
| MEDICATION NAME | DOSAGE |

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From _____ to _____ at _____ daily while in attendance.
BEGINNING DATE ENDING DATE TIME OF DAY

| | |
|---------------------|-------|
| PARENT'S SIGNATURE: | DATE: |
|---------------------|-------|

MEDICATION CHART
Staff Documentation of Medicine Administration

| DATE | TIME GIVEN | STAFF SIGNATURE |
|------|------------|-----------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Upon Completion, return medicine to parent or destroy, and place form in child's record.

| | |
|-------|------|
| STAFF | DATE |
|-------|------|

**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER