

Dear Parents / Guardians,

Montessori School Of Aurora Inc.

Every childcare center in Colorado is required by law to train specific staff to give medication at their center. This training is recognized and approved by:

- Colorado Department of Education
- Colorado Department of Public Health and Environment
- Colorado State Board of Nursing
- Colorado Department of Human Services – Division of Childcare

After the staff member successfully completes the medication training, your center’s nurse consultant will delegate the administration of medication to selected staff members. This process has been developed to ensure safe and proper administration of medication. Non-compliance is considered a childcare licensing violation.

This letter describes the authorization forms required in order to administer medication in a child care center.

- Children needing any medication during program hours require completed **Medication Authorization(s)** that is signed by the child’s guardian and health care provider. Medication includes all prescription medication, over the counter medication, nebulizers and inhaled medication. No Exceptions. Form attached. Note: Program staff can only administer medication if the authorization is completed by your health care provider and with parent/guardian signature.
- Children with **Severe Allergies** requiring medication need a completed health care plan that is signed by your health care provider. Form attached.
- Children with **Asthma** that regularly require asthma medication during program hours need a completed asthma health care plan that is signed by your health care provider. Form attached.
- Children with **Special Health Conditions** need a completed health care plan signed by your health care provider. This plan will be individually designed for your child; in collaboration with the program’s nurse consultant, program staff and the child’s parent/guardian.

We recognize this process requires your valuable time and patience; therefore, we are very appreciative of your attention in this matter. If you have any questions please feel free to contact your center’s nurse consultant.

To Be Completed By Parent/Guardian and Returned to your Child’s Teacher

1. Does your child have any food exclusions due to an allergic reaction to this food?
Yes _____ No _____

If yes, please list food and your child’s reaction to exposure:

Food	Reaction	Medication
_____	_____	_____
_____	_____	_____

2. Does your child have any other allergies requiring medications or special attention?
Yes _____ No _____
3. Does your child have Asthma and regularly requires medication during program hours?
Yes _____ No _____
4. Does your child have a special health condition (such as seizures, diabetes, feeding tube, oxygen, etc.) that requires special attention by center staff?
Yes _____ No _____

_____ I will provide a Health Care Plan signed by my child’s health care provider.
 _____ I understand that the nurse consultant will review the health care plan and is available to assist in this process.
 _____ My child doesn’t have any special health care needs at this time.

Child’s Name _____ Birth Date _____
 Parent’s Signature _____ Date _____