

! This release allows Jasper Mountain to arrange for medical care for your child, to administer prescription and non-prescription medications, and provides opportunity for you to assent or request modifications to the Agency's medical communication and emergency transportation practices.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have the authority to sign this authorization and release on behalf of my child because my child is a minor and I am the child's parent or legal guardian. I hereby give my consent for the above-named child as follows:

**1. MEDICAL AND DENTAL TREATMENT & COMMUNICATION** I acknowledge that the above named child is enrolled in a Jasper Mountain residential treatment program (hereafter known as "Agency"). I understand that whenever possible, decisions regarding each resident's medical care will be made by the child's parent or guardian. This release, however, gives the Agency permission to secure and arrange for any necessary medical, surgical, or dental treatment of my child including exchanging information with the providing physician received pursuant to a Release of Information (ROI). This authorization further gives permission to any physicians, hospitals, dentists, or other care providers to examine, treat, provide surgery and hospital care, and to share information as requested by the Agency. I authorize my child's physician and dentist to be informed by the Agency of pertinent medical or mental health issues relevant to caring for my child's health and well-being.

In a medical emergency or for serious medical situations, I understand that the Agency's policy is to contact the child's parent/guardian at the earliest opportunity following immediate attendance to an emergency. For medical issues of a non-emergency nature (for example, fevers, colds, minor ailments) the Agency notifies parents/guardians during regular communication with the child's therapist. Please initial the following:

INITIAL ONE

\_\_\_\_\_ I agree to be informed of minor medical issues according to this general procedure.

\_\_\_\_\_ I wish to be informed of minor medical issues according to another criteria, provided in writing by me and attached to this agreement.

**2. EMERGENCY MEDICAL TRANSPORT** In the event of a medical emergency involving agency clients, Jasper Mountain's policy is as follows: *In the event of a medical emergency for a client when a parent cannot be immediately reached, the staff person working with the child will consult with agency leadership personnel if at all possible to determine the safest and most appropriate method of transport. Agency policy requires that an ambulance must be used if any of the following are true: the child's respiration is affected, the child's consciousness is affected, there is a possibility of unknown medical concerns such as internal trauma, or there is serious bleeding. If an ambulance is not required, agency staff will transport the child to a medical facility by the safest and most efficient means. If a child has a medical emergency, whether transported to a medical facility or not, the child's parent or guardian will be informed at the earliest opportunity following immediate attendance to the emergency.*

Given the above described policy, I authorize Jasper Mountain as indicated below (please initial the statement that applies):

INITIAL ONE

\_\_\_\_\_ I authorize the agency to address emergency medical care in accordance with the above described policies and procedures.

\_\_\_\_\_ I wish to have emergency medical transportation issues to be addressed according to another procedure, provided by me, and attached to this agreement.

### **3. Standing Orders**

At times, a child may become ill. In some circumstances illness can be prevented or treated by over-the-counter medications (OTC medications), treatments and immunizations. It is the Agency's practice to give all OTC medications, treatments and immunizations in accordance with the agency doctor's standing orders, under the supervision of the agency nurse, and consistent with any special medical needs or conditions for each individual child (such as allergies, etc). The standing orders are attached to this release and describe the amounts and types approved for as-needed use by agency programs. Please initial the following statement that would apply to your child's case

INITIAL ONE

\_\_\_\_\_ I give my permission for my child to receive the OTC medications, treatments and immunizations as described in the attached Standing Orders.

\_\_\_\_\_ I have provided in writing my desired modifications to the attached Standing Orders and ask that this protocol be followed for my child.

### **5. PRESCRIPTION MEDICATIONS**

I understand that medication may be one treatment option for my child. I am aware that I must give informed consent in writing for the initial administration of any medication to my child or to any subsequent change in the class of medication. This document gives my expressed informed consent for Jasper Mountain to administer medication prescribed to my child by this child's primary care physician and/or the psychiatrist. I understand that I may refuse the administration of medication to the above named child, either verbally or in writing, and that in doing so there may be some associated risks involved.

Current Medications: Upon intake into the Jasper Mountain residential program, the above named child is taking the following medications (please indicate "none" if your child is not currently taking medications):

I give my permission for Jasper Mountain to administer the above listed medications by signing the Authorization & Release section of this document below.

**5. AUTHORIZATION & RELEASE**

My signature below indicates that I have been informed of above listed procedures regarding health services, health communication, emergency transportation procedures and medication administration. I have been given opportunity to approve or request modifications to these procedures, and have provided any requested modifications in writing, and have attached them to this agreement. I hereby authorize the agency to carry out medical services as outlined in this release and addendum(s).

Parent/Guardian Name (Please Print): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## STANDING ORDERS

### Medications, Treatments and Immunizations

- ✓ Children with no documented allergies to the preparations listed below may have them administered for the symptom listed, under the direction of the agency nurse.
- ✓ All remedies given are to be documented as given and with the results on the MAR.
- ✓ Generic equivalents may be used.

#### PAIN and/or FEVER -for fever over 100 degrees notify Licensed Nurse

**Ibuprofen** Dose - every 6-8 hours as needed

Child's Weight (pounds)	36-47	48-59	60-71	72-95	96+	lbs
Liquid 100 mg / 1 tsp	1½	2	2½	3	4	teaspoons
Adult 200 mg tablets		1	1	1½	2	tablets

**Acetaminophen (Tylenol)** Dose - every 4-6 hours as needed

Child's Weight (pounds)	36-47	48-59	60-71	72-95	96+	lbs
Liquid 160 mg / 1 tsp	1½	2	2½	3	4	teaspoons
Adult 325 mg tablets	--	1	1	1½	2	tablets

#### ALLERGIES and ALLERGIC REACTIONS

**Loratadine (Claritin)** 10 mg tabs - one tab non-drowsy for children over 6yrs old - every 24 hrs

**Cetirizine (Zyrtec)** 10 mg tabs - one tab for children over 6yrs old - every 24 hrs

**Diphenhydramine (Benadryl)** Liquid or Tabs – every 6 hours as needed

Child's weight (pounds)	38-49	50-99	100+	lbs
Liquid 12.5 mg / 1 tsp	1½	2	--	teaspoons
Tablets 25 mg	½	1	2	tablets

#### MILD COUGH and/or SORE THROAT

**Cough Drops (Ricola)** mild infrequent coughs - as needed

**Honey:** 1 teaspoon, and/or Hot tea with honey

#### NASAL CONGESTION, SINUS PRESSURE and/or PERSISTANT COUGH -notify Licensed Nurse

**Children's Sudafed** – every 4 hours as needed

Child's weight (pounds)	38-49	50-99	100+	lbs
Liquid .5 mg / 1 tsp		1½	2	-- teaspoons

#### CANKER SORES

Give **Ibuprofen** at dose above



## STANDING ORDERS

### Medications, Treatments and Immunizations

#### CONSTIPATION

**Polyethylene glycol (Miralax):** Mix ½ to 1 capful in liquid - drink 1-2 times daily as needed

#### HEART BURN - INDIGESTION - SOUR STOMACH

**Calcium Carbonate (Tumms)** - take 1 Tab 1-4 times daily as needed

#### SKIN WOUNDS ABRASIONS and/or IRRITATIONS

***WASH affected area with soap and water then pat dry with paper towel or clean cloth***

**Abrasion, cut, scrape:** Apply First Aide Liquid with cotton swab and then apply bandaid

**Itchy skin or rash:** **Anti-Itch Cream**(Diphenhydramine or Hydrocortisone Cream 1%) -apply as needed

**Athletes feet, ringworm, jock itch:** **Anti-Fungal Cream** (clotrimazole 1%) apply 1-2 X a day

**Insect Bites:** **Calamine Lotion or Calagel** -apply to clean, dry skin as needed

**Minor wounds:** wash with soap and water, apply **Antibiotic Ointment** then band aid

**Ear Wax Removal:** 1<sup>st</sup> **Olive Oil**, 3-5 drops, plug ear with cotton ball, allow 30min. to dissolve wax

2<sup>nd</sup> (**Carbamide Peroxide**) -following instructions of Licensed Nurse

**Lice and Nits:** apply **Nix or Rid** as directed on box

#### Poison Ivy/Poison Oak Type Skin Irritations

Immediately after exposure: **Tecnu Outdoor Skin** – see directions on label

Itching and skin irritations: **Calamine Lotion** –apply to clean, dry skin

#### OTHER:

**Multi-vitamin:** 1 tablet daily

**Tuberculosis Skin Test- PPD :** Administered by Licensed Nurse

**Influenza vaccine:** Per PCP recommendation; administered by Licensed Nurse

**Routine immunizations:** Per PCP recommendation; administered by Licensed Nurse

**\*\* Please initial if you are ok with these non-required immunizations: \*\***

**HPV vaccine**\_\_\_\_\_

**Meningococcal**\_\_\_\_\_

As ordered by [signature on file] **Franc Strgar, M.D.**

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_