**INHALED MEDICATION: PHYSICIAN’S CHECKLIST (LICENSED FACILITIES)**
**(CHILD’S EVALUATION FOR APPROPRIATENESS OF CARE)**

**PART A – INFORMATION TO BE COMPLETED BY PHYSICIAN**

<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>Birthdate:</th>
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</table>

**Assessment of Stability of Child’s Medical Condition**

Is the child’s medical condition stable enough for a layperson with instruction/ training to safely administer medication to and properly care for the child in a childcare setting?  □ Yes  □ No  
Please explain: ___________________________________________________________________________________________________________

**Designation of Person to Provide Instruction on Inhaled Medication**

If the answer to the above question is yes, each person who administers the medication to the child must be instructed on how to provide that care by a competent person designated by the child’s physician. Please indicate the person you designate to provide this instruction with regard to the above-named child (may be the child’s authorized representative).

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>
| Title or Relationship to Child: | ___________________________________________________________________________________________________________

Please provide specific steps for layperson to administer this medication to the child. The instructions must be updated annually, or whenever the child’s needs dictate, and must include:

- The name and use of the medication.
- The name and use of any equipment and supplies needed.
- The proper dosage/ amount.
- The proper storage and cleaning.
- The method of administration.
- The time schedules by which the medication is to be administered.
- A description of any potential side effects and the expected protocol.
- A description of how to identify and respond to an emergency related to this medication/ condition.
- Whether the child should rest and when the child may return to normal activities.

**PART B: INHALED TRAINING LOG**

<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>Date of Training:</th>
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<table>
<thead>
<tr>
<th>Name of Designated Trainer:</th>
<th>Date of Training:</th>
</tr>
</thead>
</table>

Name of all Staff Present during Training:

<table>
<thead>
<tr>
<th>Signature of Trainer:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signatures of Staff:</th>
<th>Date:</th>
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</thead>
</table>

The YMCA of San Diego County is dedicated to improving the quality of human life and to helping all people realize their
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 __________________________

LIC 9166 (2/01)