**Treatment Policy**

The nursing staff of “Your Child’s Place” has been trained to administer prescription treatments that are prescribed by a physician, CRNP, or Physician’s Assistant (PA) for a child enrolled. All treatments must be prescribed. The following requirements must be observed:

* A prescription for the treatment must be on file prior to the administration.
* A Nurse will administer a prescription treatment once written instructions are provided from the individual who prescribed the treatment. “Your Child’s Place” will review the procedure used by the parents at home and the directions provided by a participating home health agency. A specific procedure will be developed, and the staff trained.
* The Medical Director will be consulted about the procedure for approval or revision as needed.
* Parents are responsible for providing all equipment needed to perform a treatment or procedure.
* Disposable equipment should be marked with the child’s name and will be stored in an area designed for the child and/or it will be stored in a locked area of the room in which the child is located and out of the reach of all children.
* Treatment equipment will be stored in accordance with the manufacturer’s or health professionals’ instructions on the label. Solutions that are to be refrigerated will be maintained in the refrigerator in the locked clean utility room.
* Parents will provide written consent for the Nurses to administer the treatment.

The nurse administering the treatment will document on the child’s daily record and the child’s individual treatment log. Treatments that are not given or refused will have the rationale documented in the same logs. No other staff member but a Nurse may administer the treatment.

**Permission for Administration of Treatments**

Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALLERGIES: \_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the physician for the above named child, I order the following list of prescribed treatments that will be administered at “Your Child’s Place”. I understand that no treatment will be administered without a physician’s written order by the nursing staff of “Your Child’s Place”.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Permission /Signature Date

***Treatment Schedule***

|  |  |  |
| --- | --- | --- |
| Treatment | Time | Special Instructions/Comments |
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|  |  |  |
|  |  |  |
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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian, of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child) give my permission for the nursing staff of “Your Child’s Place” to administer the following prescribed treatment during their time of attendance at the center. I understand that it is my responsibility to notify the center of any changes that may occur in my child’s treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Permission /Signature Date