

HOME TELEPHONE NUMBER		HOME TELEPHONE NUMBER	
ADDRESS OF AUTHORIZED REPRESENTATIVE		ADDRESS OF AUTHORIZED REPRESENTATIVE	
DATE	SIGNATURE OF AUTHORIZED REPRESENTATIVE		

I, _____ (PRINT NAME OF AUTHORIZED REPRESENTATIVE), give my consent for _____ (PRINT NAME AND ADDRESS OF CHILD CARE FACILITY), who work(s) at DISCOVERY LEARNING CENTER, 4444 SAN JUAN AVE, FAIR OAKS, CA 95628, to administer inhaled medication to my child, _____ (PRINT NAME OF CHILD), and to contact my child's health care provider. 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.

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.**

NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES