FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF SAN DIEGO COUNTY
Child & Youth Development

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

PART A – INFORMATION TO BE COMPLETED BY PHYSICIAN

Name of Child: _____ **Birthdate:** _____

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).

Name _____ Phone Number: _____
Address _____
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.
- How long the child may need to be under direct observation following administration of medication.
- Whether the child should rest and when the child may return to normal activities.

Physician:	Date of Last Physical Exam:	Current Date:
Address:		Telephone:
Signature:		

☐ PHYSICIAN ☐ PHYSICIAN'S ASSISTANT ☐ NURSE PRACTICTIONER

PART B: INHALED TRAINING LOG

Name of Child:

Name of Designated Trainer:	Date of Training:
Name of all Staff Present during Training:	
Signature of Trainer:	**Date:**

Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
Signatures of Staff:		Date:		Signatures of Staff:		Date:	
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