DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

STATE OF WISCONSIN

Date Correction Plan Due	NONCOMPLIANCE STATEMENT AND CORRECTION PLAN	TO FILE A COMPLAINT CALL
11/18/2024		608-422-6765

Use of Form: This form is used by certification / licensing staff to identify statute and / or administrative rule violation(s) and to outline imposed plans of correction, if applicable. This form is used by certified operators / licensed centers to meet the requirements of DCF 202.065, DCF 250.04(2)(i) and (3)(d), DCF 251.04(2)(L) and (3)(f)., DCF 252.41(1)(L) and (2)(k). Failure to submit an appropriate correction plan by the due date listed above may result in sanctions identified in the statute and / or administrative rule. Public Schools may submit plans of correction however are not required to do so.

Instructions: The Noncompliance Statement below identifies the violation(s) of child care statute and / or administrative rule identified by the certification / licensing specialist. Complete the section labeled "Correction Plan" by indicating the steps that will be taken to address and correct each of the listed noncompliance(s). Identify expected completion date(s) for each item. Return the original to your certification / licensing specialist for approval and retain a copy. If this is a licensed child care, post your copy of the noncompliance statement and correction plan near the license in accordance with Wis. Stat. 48.657. This request for a correction plan is not an order imposing a sanction or penalty pursuant to Wis. Stat. 48.715. If the department decides to apply a statutory sanction and / or penalty for facts arising from this finding or a future finding, you will be given a notice of the sanction and / or penalty and your appeal rights.

Name - Certified Operator / Licensed Center	Provider Number / Facility ID Number
Little Eagles Child Care	8000590278 / 006 - 2007418

Address - Facility (Street, City, State, Zip Code)	Telephone Number	Date - Regulation Visit
800 Grayside Ave Mauston WI 539481853	608-847-5451	10/24/2024

	Rule/Statute Number Noncompliance Statement	Correction Plan	Expected Completion Date	Verification Date
1	251.07(6)(f)5. **Medication Administration - As Labeled & Authorized** Description: Medications could not be administered as labeled when over the counter allergy medication was maintained for a two year old, when the medication label indicated that children under five years old should not be given the medication without consulting a physician. No physicians directions were found on file.	Spoke with parent explaining Dr Note was written for name brand medication. Parent brought in generic. Parent called Doctor to get correct note regarding medication. We will ensure that the medication (generic/name brand) matches what was specifically written by the provider. Received form from provider with the correct (generic) name brand medication	11/11/24	

NAME - Agency Worker
Robert Mccoy

Date Issued
11/4/2024

SIGNATURE - Certified Operator or Designee / Licensee or Designee

Date Signed
11/6/2024

Medication Request/Consent Form

Rev 8/99

Mauston School District, Mauston Wisconsin

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school. One form is required for EACH medication.

STUDENT: Temperance McGlynn School: Mauston/Little Eagles Grade: _____

Address: _____ Phone: _____ Birthdate: _____

Physician Name: Dr. Ryan Plamann Address: _____ Phone: _____

MEDICATION/PROCEDURE:

Name of medication or procedure: Equate Childrens Allergy Relief 1.25mg/5mL

Reason for medication/procedure (diagnosis): Peanut Allergy

Time(s) to be given at school: PRN

Route: By mouth X
Injected _____
Inhaled _____
Other route: _____

Dose at School: 6.25mg | 2.5mL

Dates to be given: From: 2024 To: 2025

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given:

Accidental peanut encounter

How soon can administration of PRN medication be repeated? Q4°

Any additional directions: _____

Precautions/Unfavorable Reactions: _____

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian/responsible adult.
- I give my permission to have my child's photo displayed on this form. Yes ____ No ____
- I understand that medication will be given by non-medically trained school personnel.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- ASTHMA INDALERS AND EPI PENS ONLY: This student is capable of self-administration and may carry inhaler or EPI pen and self-administer at school. Yes ____ No X

Signature of parent/Legal Guardian | 608-778-2808 Telephone Home Business | 11/12/2024 Date

PHYSICIAN ORDER: (complete for all prescription Medication and all Procedures)

The above medication/ procedure is to be administered/ performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/ procedure and understand medication will be given by non-medically trained school personnel.

Please contact me if the following symptoms occur: ANY

ASTHMA INHALERS AND EPI PENS ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer at school. Yes ____ No ____

Physician's Signature | 10/25/24 Date | RYAN A. PLAMANN, MD Printed Name & Address of Physician | 608-562-3111 Phone Number

New Lisbon Family Clinic
901 W. Bridge St.
New Lisbon, WI 53950