PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART

NOTE: Regulation Section 101221 requires the following information be on file.

CHILD CARE CENTER NAME:	LICENSE NUMBER:	DATE:

PARENT'S INSTRUCTIONS:

- 1. All prescription and nonprescription medications shall be maintained with the child's name and shall be dated.
- 2. Prescription and nonprescription medications must be stored in the original bottle with unaltered label. Medications requiring refrigeration must be properly stored.
- 3. Prescription and nonprescription medication shall be administered in accordance with the label directions.
- 4. Written consent must be provided from the parent, permitting child care facility personnel to administer medications to the child. Instructions shall not conflict with the prescription label or product label directions.

CHILD'S NAME	DATE OF BIRTH
MEDICATION NAME	DOSAGE

I authorize child care personnel to assist in the administration of medications described above to the child named above for the following medical condition/s:

From	BEGINNING DATE	ENDING DATE At	e of Day daily while in attendance.
PARENT'S SIGNA	ATURE:		DATE:
MEDICATION CHART Staff Documentation of Medicine Administration			
DATE	TIME GIVEN	STAFF SIGNATURE	
DATE	TIME GIVEN	STAFF SIGNATURE	
DATE	TIME GIVEN	STAFF SIGNATURE	
DATE	TIME GIVEN	STAFF SIGNATURE	
DATE	TIME GIVEN	STAFF SIGNATURE	

Upon completion, return medicine to parent or destroy, and place form in child's record.

STAFF	DATE



Allergy and Anaphylaxis Emergency Plan

Name:		Weight:	lbs / kg
Date of Plan:	Age:		
Allergies:			

Child has asthma: yes / no (if yes, higher chance of a severe reaction) Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction) Child may carry medicine: yes / no Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)

□ **The "Always-Epinephrine" Option:** If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

Attach child's photo

**IF IN DOUBT, GIVE EPINEPHRINE! ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

For SEVERE Allergy or Anaphylaxis	Give EPINEPHRINE!
What to look for:	What to do:
If child has ANY of these symptoms after eating a	1. Inject epinephrine right away! Note the time.
food or having a sting, give epinephrine	2. Call 911
Breathing: trouble breathing, wheeze, cough	Ask for ambulance with epinephrine
> Throat: tight or hoarse throat, trouble swallowing	Tell rescue squad when epinephrine was given
or speaking	3. Stay with child and:
Brain: confusion, agitation, dizziness, fainting,	Call parents
unresponsiveness	Give a second dose of epinephrine if symptoms
<u>Gut</u> : severe stomach pain, vomiting, diarrhea	worsen or do not get better in 5 minutes
Mouth: swelling of lips or tongue that affects	Keep child lying on back. If the child vomits or has
breathing	trouble breathing, keep child lying on their side
Skin: face color is pale or blue, many hives or	4. Give other medicine (e.g. antihistamine, inhaler) if
redness over body	prescribed. Do not use other medicine in place of
	epinephrine.
For MILD Allergic Reaction	Give Antihistamine and Monitor the Child
What to look for:	What to do:
If child has mild symptoms, or no symptoms but a	1. Give antihistamine if prescribed
sting or ingestion of the food is suspected, give	2. If in doubt, give epinephrine
antihistamine and monitor the child.	3. Call parents
Mild symptoms may include:	4. Watch child closely for 4 hours
Skin: a few hives, mild rash, mild swelling, OR	5. If symptoms worsen, give epinephrine (See "For
Mouth/nose/eyes: itching, rubbing, sneezing, OR	SEVERE Allergy and Anaphylaxis")
<u>Gut</u> : mild stomach pain, nausea or discomfort	
Note: if the child has more than one mild symptom	
area affected, give epinephrine	
Medicine/Doses	
Epinephrine (intramuscular in thigh): □ 0.15 mg	□ 0.30 mg
Antihistamine (by mouth): Diphenhydramine	_mg (ml) □ Other:mg (ml)
Other medications: Albuterol 2-4 puffs other:	
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PROVIDER (Electronic) Signature Date N	ame (printed) Phone FAX
PARENT/GUARDIAN Signature Date N	ame (printed) Phone
Reviewed by school nurse:	Date:

Allergy and Anaphylaxis Emergency Plan

Child's name:______Date of Plan: ______

Additional Instructions:

Contacts

Doctor name (print): Office Address:	Office Fax: ()
Parent/Guardian name (print):	Phone:
Parent/Guardian name (print) :	Phone:
Other Emergency Contacts	
Name/Relationship:	Phone:
Name/Relationship:	Phone: