

Allergy and Anaphylaxis Medication Administration Authorization Plan

This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**

Page 1 to be completed by the Authorized Health Care Provider.

FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216

Place Child's Picture
Here (optional)

CHILD'S NAME: _____ Date of Birth: ____/____/____ **Date of plan:** _____
 Child has **Allergy** to _____ ☐ Ingestion/Mouth ☐ Inhalation ☐ Skin Contact ☐ Sting ☐ Other _____
 Child has had anaphylaxis: ☐ Yes ☐ No
 Child has asthma: ☐ Yes ☐ No (If yes, higher chance severe reaction) Child
 may self-carry medication: ☐ Yes ☐ No
 Child may self-administer medication: ☐ Yes ☐ No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth ☐ Call Parent ☐ Call 911	Epinephrine(EpiPen) IM Injection in Thigh ☐ Call 911 ☐ Call Parent
is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

- 1) **Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		
PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)		

Maryland State Department of Education
Office of Child Care
Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION																	
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.																	
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION														
CELL PHONE #		HOME PHONE #	WORK PHONE #														
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency															
Parent/Guardian 1																	
Parent/Guardian 2																	
Emergency 1																	
Emergency 2																	
Section IV. CHILD CARE STAFF USE ONLY																	
Child Care Responsibilities:	<table style="width: 100%; border: none;"><tr><td style="width: 60%;">1. Medication named above was received</td><td style="width: 40%; text-align: right;">☐ Yes ☐ No</td></tr><tr><td>2. Medication labeled as required by COMAR</td><td style="text-align: right;">☐ Yes ☐ No</td></tr><tr><td>3. OCC 1214 Emergency Card updated</td><td style="text-align: right;">☐ Yes ☐ No</td></tr><tr><td>4. OCC 1215 Health Inventory updated</td><td style="text-align: right;">☐ Yes ☐ No</td></tr><tr><td>5. Modified Diet/Exercise Plan</td><td style="text-align: right;">☐ Yes ☐ No ☐ N/A</td></tr><tr><td>6. Individualized Plan: IEP/IFSP</td><td style="text-align: right;">☐ Yes ☐ No ☐ N/A</td></tr><tr><td>7. Staff approved to administer medication is available onsite, field trips</td><td style="text-align: right;">☐ Yes ☐ No</td></tr></table>			1. Medication named above was received	☐ Yes ☐ No	2. Medication labeled as required by COMAR	☐ Yes ☐ No	3. OCC 1214 Emergency Card updated	☐ Yes ☐ No	4. OCC 1215 Health Inventory updated	☐ Yes ☐ No	5. Modified Diet/Exercise Plan	☐ Yes ☐ No ☐ N/A	6. Individualized Plan: IEP/IFSP	☐ Yes ☐ No ☐ N/A	7. Staff approved to administer medication is available onsite, field trips	☐ Yes ☐ No
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Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)														

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE