Chesterbrook United Methodist Church
Preschool and After Care

Allergy Action Plan

Student Name: _____
Allergy to: _____
DOB: / /
Asthmatic: *Yes ☐ No ☐
***High Risk for Reaction**

Signs of Allergic Reaction

Symptoms	**✓Give Medication**	
If exposed to allergens but no symptoms give...	☐ EpiPen	☐ Benadryl
Mouth: itching, swelling of tongue, lips or mouth give...	☐ EpiPen	☐ Benadryl
***Throat:** itching and/or tightness of throat, coughing give...	☐ EpiPen	☐ Benadryl
Skin: hives, itching, rash, swelling of face give...	☐ EpiPen	☐ Benadryl
Body: nausea, abdominal cramping, vomiting, diarrhea give...	☐ EpiPen	☐ Benadryl
***Lung:** shortness of breath, coughing/wheezing give...	☐ EpiPen	☐ Benadryl
***Heart:** itching, swelling of tongue, lips or mouth give...	☐ EpiPen	☐ Benadryl
Other: _____	☐ EpiPen	☐ Benadryl

***All symptoms above pertaining to heart, lungs, and throat can be potentially life threatening.**

Minor Reaction

1. **If symptom(s) are:** _____

   give _____.

2. **Call Contacts:** Mother_____ Father: _____

   Emergency Contacts:_____.

Major Reaction

1. **If exposed to allergen/food(s) and symptoms are:** _____

   _____

   give _____ **IMMEDIATELY.**
   (medication and dosage)

2. Call 911 after giving EpiPen injection. Prepare to give a second dose of Epinephrine in 15 minutes is ambulance has not arrived.

3. **Then call:** Mother_____ Father: _____

   Emergency Contacts:_____.

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Emergency Contacts

#1
Name:_____
Relationship: :_____
Phone: :_(___)_____

#2
Name:_____
Relationship: :_____
Phone: :_(___)_____

#3
Name:_____
Relationship: :_____
Phone: :_(___)_____

#4
Name:_____
Relationship: :_____
Phone: :_(___)_____

Parental Permission

I _____hereby authorize the *MAT/**PMAT trained staff of Chesterbrook United Methodist Church(CUMC) Preschool and After Care to administer a needed epinephrine auto-injector and/or Benadryl dosage to my child _____ in the event of an allergic reaction; during school time and during before or after school activities. I authorize the second dose of epinephrine to be administered 15 minutes after the first if symptoms have not improved, and ambulance has not yet arrived . CUMC Preschool and After Care's teachers and employees, incur no liability, as a result of any injury from an administration of medication and/or epinephrine auto-injector. I agree to release, indemnify, and hold harmless the school teachers, or employees from lawsuits, claim expense, demand or action, etc., against them for administering this injection/dosage.

I am the parent / legal guardian of this CUMC Preschool and After Care student. I have read and understand what is being requested, and I give my permission for the needed treatment of my child.

_____/__/_____

Parent Signature **Print Name** **Date**

* MAT Certified - The MAT course certifies providers or staff in child day programs to administer prescription medication in a child care setting using seven routes: oral, topical, inhaled, medicated patches, eye, ear and emergency injection of epinephrine using an auto-injector device.

PMAT Certified- The PMAT course trains providers in child day programs, who do **not ordinarily administer medications but who supervise children (e.g. bus drivers), to administer an emergency injection of epinephrine using an auto-injector device (EpiPen) and/or to apply prescription topical ointment or cream (e.g., diaper ointment).

Handout 2.4

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to (child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility telephone number:	26. County
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____. Once the medication has been discontinued, I understand that if my child (date) requires this medication in the future, a new written medication consent form must be completed.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child._____
34. Licensed Authorized Prescriber's Signature:
35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE:_____ By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature:

Handout 2.4

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe): _____

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:
Required for Long-Term medication or when dosage directions state "consult a physician".

This is a double-sided form