MEDICATION EMERGENCY ACTION PLAN **School Year 20__ - 20__**

Patient Name: _____ **Age:**_____ **D.o.B:**_____

Allergies: _____

Asthma: Yes ☐ **No** ☐ **Other conditions**_____

ALLERGIC REACTION TREATMENT:

Symptoms:

If a child with allergies exhibits any of the following symptoms,

Mouth	Itching, swelling of lips and/or tongue
Throat	Itching, tightness/closure, hoarseness
Skin	Itching, hives, redness, swelling
Gut	Vomiting, diarrhea, cramps
Lung	Shortness of breath, cough, wheeze
Heart	Weak pulse, dizziness, passing out

Then, give the child:

Diphenhydramine HCl:	Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.
Other Antihistamine:	Medication: _____Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.
Epinephrine ☐ Epi Pen Jr ☐ AUVI-Q	Medication: _____Dosage: _____ If rescue squad has not arrived within 15 minutes, should child be injected a second time?: Yes ____ No _____
Other Medication	Medication: _____Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.

OTHER CONDITION TREATMENT:

If a child with _____, presents with_____

_____

_____

Then, give the child:

Other Medication	Medication: _____Dosage: _____
Other Medication	Medication: _____Dosage: _____

Physician's Signature: _____***Phone Number:*** _____***Date:***_____

EMERGENCY CALLS

**** CALL 911**

Parent 1:_____ Parent 2_____

Phone Number: _____ Phone Number:_____

Emergency Contact: _____Relationship to child_____

Emergency Contact Phone Number: _____

Physician: _____Phone Number_____

Allergist or other Specialist: _____Phone Number_____

My child has required the use of their emergency medication _____ times, most recently on _____.

This was necessary because he/she exhibited the following symptoms: _____

_____

The symptoms were caused by _(food, bee, sting, etc.) : _____

_____ _____.

Parent Signature: _____ Date: _____

***** All medication must be presented in original packaging and expire after the end of the current school year. ******

MEDICATION AUTHORIZATION *(to be filled out by the physician)*

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____ during center hours and that this medication may be administered by MAT trained staff.

Reason child is taking medication: _____

□ **Epi Pen** □ **Epi Pen JR** □ **AUVI-Q** Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: □ Current school year □ For the following time period: ___/___/___ - ___/___/___ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: □ **yes** □ **no**	□ **Diphenydramine HCl:** Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: □ Current school year □ For the following time period: ___/___/___ - ___/___/___ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: □ **yes** □ **no**	□ **Other Medication:** _____ Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: □ Current school year □ For the following time period: ___/___/___ - ___/___/___ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: □ **yes** □ **no**

_____ _____ _____
Printed Name of Physician Signature of Physician Date

To Be Completed by Parent or Guardian

I, _____, the parent or guardian of_____, hereby authorize Temple Rodef Shalom Early Childhood Center staff to facilitate the use of the medication prescribed above as directed by this authorization to my child during school hours. I agree to release, indemnify, and hold harmless Temple Rodef Shalom, including the staff and Board of Directors, from any and all lawsuits, claims, expenses, demands, or actions, etc. against them for assisting my child with the use of this medication. The staff at Early Childhoood Center is directed to comply with the physician and parent/guardian orders set forth in accordance with the provisions above.

I understand that the person who will administer the medication has been trained through the Commonwealth of Virginia's MAT training program.

I agree to furnish said medication in the container supplied by the drug store with the label intact.

I understand that I must replace my child's emergency medication prior to the expiration date. If the medication is not replaced by the expiration date, I understand that my child may not attend school until new medication is received.

As required by licensing, any unclaimed expired medication will be disposed of after 14 days.

_____ _____
Signature of Parent or Guardian Date

Social Services will not allow us to accept medication until this form is filled out in its entirety. All medications must be in original packaging. Prescription medication must have pharmacy label.

PARENT REQUEST TO DISCONTINUE MEDICATION

I, _____parent/legal guardian, request that the medication indicated on the front of this Medication Authorization form be DISCONTINUED on _____(date) and am removing it from the premises. Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written Medication Authorization form must be completed.

_____ _____

Signature of Parent or Guardian Date