

**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 <input type="checkbox"/> Epi Pen Jr <input type="checkbox"/> 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.

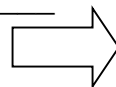
**OTHER CONDITION TREATMENT:**

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: \_\_\_\_\_

<input type="checkbox"/> <b>Epi Pen</b> <input type="checkbox"/> <b>Epi Pen JR</b> <input type="checkbox"/> <b>AUVI-Q</b> Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: <input type="checkbox"/> Current school year <input type="checkbox"/> For the following time period: ____/____/____ - ____/____/____ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>	<input type="checkbox"/> <b>Diphenhydramine HCl:</b> Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: <input type="checkbox"/> Current school year <input type="checkbox"/> For the following time period: ____/____/____ - ____/____/____ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>	<input type="checkbox"/> <b>Other Medication:</b> _____ Amount/Dosage to be given: _____ Route of administration: _____ Frequency to be administered: _____ Date of Prescription: _____ Duration: <input type="checkbox"/> Current school year <input type="checkbox"/> For the following time period: ____/____/____ - ____/____/____ (mo) (day) (year) (mo) (day) (year) This medication needs to be brought on field trips by a staff member: <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>
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\_\_\_\_\_  
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 Childhood 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