

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)



CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? No Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

| Symptoms: The child has ingested a food allergen or exposed to an allergy trigger: But is <i>not</i> exhibiting or complaining of any symptoms | Give this Medication | |
|--|----------------------|---------------|
| | Epinephrine | Antihistamine |
| Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny") | | |
| Skin: hives, itchy rash, swelling of the face or extremities | | |
| Gut: nausea, abdominal cramps, vomiting, diarrhea | | |
| 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 | | |
| Other: | | |
| If reaction is progressing (several of the above areas affected) | | |

*Potentially life-threatening. The severity of symptoms can quickly change.

*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

| Medication | Dose: |
|----------------|-------|
| Epinephrine: | |
| Antihistamine: | |
| Other: | |

Doctor's Signature

Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name: _____

Phone Number: _____

| Contact(s) | Name/Relationship | Phone Number(s) | |
|-------------------|-------------------|-----------------|------|
| | | Daytime Number | Cell |
| Parent/Guardian 1 | | | |
| Parent/Guardian 2 | | | |
| Emergency 1 | | | |
| Emergency 2 | | | |

***EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.**

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] yes No

Parent/Guardian's Signature

Date

Allergy Action Plan (Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's
Picture Here

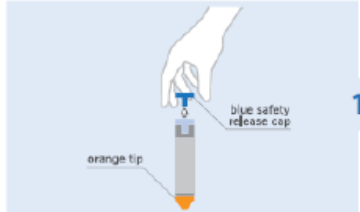
CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? No Yes (If Yes = Higher Risk for Severe Reaction)

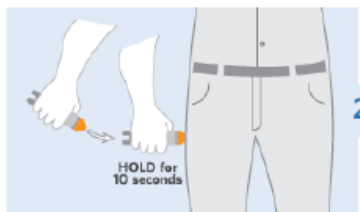
The Child Care Facility will:

- Reduce exposure to allergen(s) by: (no sharing food, _____)
- Ensure proper hand washing procedures are followed. _____
- Observe and monitor child for any signs of allergic reaction(s). _____
- Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.) _____
- Ensure that a person trained in Medication Administration accompanies child on any off-site activity. _____
- _____
- _____
- _____
- _____



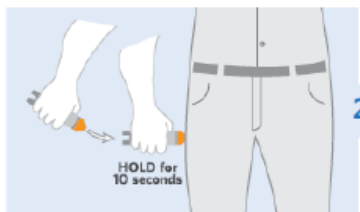
EPIPEN®
(Epinephrine) Auto-Injectors 0.1/0.15 mg

userguide



1

Pull off the blue safety release cap.

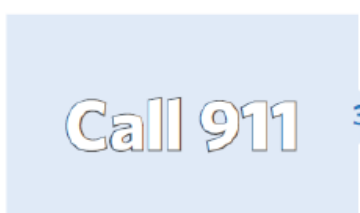


2

Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.

Please note: As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine, which you inject into your outer thigh. DO NOT INJECT INTRAVENOUSLY. DO NOT INJECT INTO YOUR BUTTOCK. Asthma may not be effective for a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.



3

Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit epipen.com.

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The Parent/Guardian will:

- Ensure the child care facility has a sufficient supply of emergency medication.
- Replace medication prior to the expiration date
- Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION

| | |
|-------------------------------------|-------------------------------|
| 1. CHILD'S NAME (First Middle Last) | 2. DATE OF BIRTH (mm/dd/yyyy) |
|-------------------------------------|-------------------------------|

| | | |
|---|-----------------------|---------------------|
| 3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR. | 3a. FROM (mm/dd/yyyy) | 3b. TO (mm/dd/yyyy) |
|---|-----------------------|---------------------|

| Medication Name | Condition Being Treated/PRN Parameters | Dose | Route | Frequency | OK to Self-Administer | OK to Self-Carry (Emerg Meds Only) |
|--|--|------|-------|-----------|--|---|
| 1 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects: | | | | | | |
| 2 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects: | | | | | | |
| 3 | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |
| Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No Known side effects: | | | | | | |

| | |
|---|---|
| 4. PRESCRIBER'S NAME/TITLE | This space may be used for the Prescriber's Address Stamp |
| TELEPHONE FAX | |
| ADDRESS | |
| CITY STATE ZIP CODE | |

| | |
|--|-----------------------|
| 5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(original signature or signature stamp only)</small> | 5b. DATE (mm/dd/yyyy) |
|--|-----------------------|

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. 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 camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

| | | |
|-------------------------------|-----------------------|--|
| 6a. PARENT/GUARDIAN SIGNATURE | 6b. DATE (mm/dd/yyyy) | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION |
| 6d. HOME PHONE # | 6e. CELL PHONE # | 6f. WORK PHONE # |

Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

| | | | |
|---|----------|--|----------|
| 7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small> | 7b. DATE | 8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small> | 8b. DATE |
|---|----------|--|----------|