Maryland State Department of Education Office of Child Care

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.

CHILD'S NAME:

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

Place Child's Picture Here (optional)

Date of plan:

Child has Allergy to Child has had anaphylaxis:	□ Vos □ No	⊔Ingestion	n/Mouth ⊔	Inhalation ∐S	kin Contact ∐Sting I	_lOthe	r	
Child has asthma: \(\subseteq \text{Yes} \)		chance severe react	ion) Child					
may self-carry medication:		chance severe react	lion) Ciliu					
Child may self-administer r		□ No						
Ciliu may sen-auminister i	nedication. Tes	L 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				☐ Call Parent IM			ephrine(EpiPen) njection in Thigh all 911 □ Call Parent	
is Not exhibiting or com	plaining of any syr	mptoms, OR						
Exhibits or complains of	any symptoms bel	ow:						
Mouth: itching, tingling,	swelling of lips, tor	ngue ("mouth feels fu	unny")					
Skin: hives, itchy rash, sw	elling of the face o	or extremities						
Throat*: difficulty swallo cough	wing ("choking fee	ling"), hoarseness, h	acking					
Lung*: shortness of brea	th, repetitive coug	hing, wheezing						
Heart*: weak or fast puls	se, low blood press	ure, fainting, pale, bl	lueness					
Gut: nausea, abdominal o	cramps, vomiting, o	diarrhea						
Other:								
If reaction is progressing (s	several of the abov	e areas affected)						
Potentially life thre	eatening. The sever	rity of symptoms can	quickly cha	nge		-1		
Medication	Medication: Bra	lication: Brand and Strength Dose		Route		Frequency		
Epinephrine(EpiPen)								
Antihistamine								
Other:								
2) Call 911: Ask fo3) Call parents. Ad4) Keep child lying5) Give other med	ine right away! No r ambulance with vise parent of the	ete time when epine epinephrine. Advise time that epinephrin the child vomits or b	rescue squa ne was given	ad when epine and 911 was o	called.		n child.	
PRESCRIBER'S NAME/TITLE					Place	stamp	here	
TELEPHONE		FAX						
ADDRESS								
DDESCRIBED'S SIGNATIID	E (Parent/guardian	a cannot sign here) (c	original signs	ature or signat	ure stamp only)	DAT	F (mm/dd/\\\\)	

Maryland State Department of Education Office of Child Care

Allergy and Anaphylaxis Medication Administration Authorization Plan

Cl	hild's Name	e:	Date of Birth:						
				PARENT/GU/	ARDIAN AUTHORIZA	TION			
I certify medica otherw compli	y that I hav ation at the vise, it will I ance with I	e legal authority facility. I unders oe discarded. I a	to consent to stand that at outhorize chil and that per	ninister the med o medical treat the end of the d care staff and COMAR 13A.1		ise the ch amed abo n authoriz scriber ind	ove, includir ed individu dicated on t	ng the admin al must pick his form to c	up the medication; communicate in
PARENT/GUARDIAN SIGNATURE				[INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION				
CELL PHONE #			Н	OME PHONE #	WORK PHONE #				
Emerge Contact	-	Name/Relatio	nship			Phone Number to be used in case of Eme			se of Emergency
Parent/0	Guardian 1								
Parent/0	Guardian 2								
Emerge	ncy 1								
Emerge	ncy 2								
				Sec	tion IV. CHILD CARE	STAFF US	E ONLY		
Child Care Responsibilities: 2. Medication labeled as re 3. OCC 1214 Emergency Ca 4. OCC 1215 Health Inventor 5. Modified Diet/Exercise F 6. Individualized Plan: IEP/I 7. Staff approved to admin			beled as requergency Card alth Inventory (Exercise Pla I Plan: IEP/IFS d to administ	uired by COMA I updated y updated n SP					
Reviewe	ed by (prin	ted name and s	signature):						DATE (mm/dd/yyyy)
			DOCL	JMENT MEDIO	CATION ADMINIST	RATION	HERE		
DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSE			SIGNATUR	RE
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