Epi-pen Medication Authorization and Care Plan for Child Day Care and Youth Camp Personnel

☐ **Authorization for the Administration of Medicine by Child Day Care personnel** must comply with Section 19a-79-9a (Group Day Care Homes and Child Day Care Centers) and Section 19a-87b-17 (Family Day Care Homes) of the Regulations for Connecticut State Agencies.

☐ **Authorization for the Administration of Medicine by Youth Camp personnel** must comply with Section 19-13-B27a(v) of the Regulations for Connecticut State Agencies.

PATIENT'S NAME:_____ DATE OF BIRTH:_____

PATIENT'S ADDRESS:_____ TELEPHONE:_____

PHYSICIAN'S NAME:_____ PATIENT'S PCP:_____

ASTHMA ☐ **YES** ☐ **NO** **FOOD ALLERGY**_____

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:

Anaphylaxis* can occur up to 2 hours following ingestion of a food allergen

_____ Administer **adrenaline** before symptoms occur, IM EpiPen Jr.___ EpiPen Adult___Auvi-Q Jr.____Auvi-Q Adult_____

_____ Administer **adrenaline** if symptoms occur, IM EpiPen Jr.___ EpiPen Adult___Auvi-Q Jr.____Auvi-Q Adult_____

_____ Administer Diphenhydramine_____tsp/___ Swish & Swallow

_____ Administer_____tsp

_____ Call 911, transport to ER if symptoms occur for further evaluation, treatment, and observation X 4 hours

The severity of symptoms can quickly change. All symptoms of anaphylaxis can potentially progress to a life-threatening situation!

_____
Physician's Signature Today's Date

1. Is this a controlled drug? ☐ Yes ☐ No Time of administration: _____
2. Medication shall be administered (if applicable) during school year _____ _____ _____ _____ _____ (dates)
3. Relevant side effects, if any, to be observed:_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Prescriber's authorization for patient to carry/self administer: ☐ Yes ☐ No _____ _____
Signature Date

Parent's authorization for patient to carry/self administer: ☐ Yes ☐ No _____ _____
Signature Date

***SYMPTOMS OF ANAPHYLAXIS**

Mouth: **Itchy mouth, swelling of lips, tongue, inside of mouth**
Skin: **Hives, itchy skin, swelling about face, eyes**
Gut: **Nausea, vomiting, cramps, diarrhea**
Throat: **Itchy throat, tightness in throat, hoarseness, drooling, hacking cough**
Lungs: **Shortness of breath, wheezing, repetitive coughing, profuse runny nose**
Heart: **Lightheadedness, dizziness, passing out: Put feet above head when giving adrenaline**

☐ **I HAVE RECEIVED, REVIEWED, AND UNDERSTAND THE ABOVE INFORMATION**

☐ **I request that medication be administered to my child as described and directed above to be administered by school / child day care /youth camp staff**

_____ ___/___/___
Patient/parent/guardian signature Date Signed

Relationship to Child_____

Address_____

Physician's Renewal Date ___/___ ___/___ ___/___

Physician's Initials _____ _____ _____

Child Care Teachers/youth camp staff Signatures:

Medication Administration Record (MAR)

Name of Child/Student_____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** _____/_____/____