

Thompson Recreation

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

- Authorization for the Administration of Medicine by Child Day Care personnel must comply with Section 19a-79-9a...
Authorization for the Administration of Medicine by Youth Camp personnel must comply with Section 19-13-B27a(v)...

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 Twinject Jr. Twinject Adult
Administer adrenaline if symptoms occur, IM EpiPen Jr. EpiPen Adult Twinject Jr. Twinject Adult
Administer Diphenhydramine tsp/ tsp/ tsp/ tsp/ Swish & Swallow
Administer tsp/ tsp/ tsp/ tsp/ 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

Physician's Renewal Date / /
Physician's Initials

Patient/parent/guardian signature Date Signed
Relationship to Child
Address

Child Care Teachers/youth camp staff Signatures: