

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.

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

Place Child's Picture
Here (optional)

CHILD'S NAME: _____ Date of Birth: ____/____/____ **Date of plan:** _____

Child has **Allergy** to _____ ☐ Ingestion/Mouth ☐ Inhalation ☐ Skin Contact ☐ Sting ☐ Other _____

Child has had anaphylaxis: ☐ Yes ☐ No

Child has asthma: ☐ Yes ☐ No (If yes, higher chance severe reaction) Child

may self-carry medication: ☐ Yes ☐ No

Child may self-administer medication: ☐ Yes ☐ 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

Antihistamine :Oral /By Mouth

☐ Call Parent

☐ Call 911

Epinephrine(EpiPen)

IM Injection in Thigh

☐ Call 911 ☐ Call Parent

is Not exhibiting or complaining of any symptoms, OR

Exhibits or complains of any symptoms below:

Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")

Skin: hives, itchy rash, swelling of the face or extremities

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

Gut: nausea, abdominal cramps, vomiting, diarrhea

Other:

If reaction is progressing (several of the above areas affected)

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

- 1) Inject epinephrine right away! Note time when epinephrine was administered.**
- 2) Call 911:** Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents.** Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back.** If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.**

PRESCRIBER'S NAME/TITLE

Place stamp here

TELEPHONE

FAX

ADDRESS

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)

DATE (mm/dd/yyyy)

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Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN AUTHORIZATION			
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. 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 child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.			
PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #		HOME PHONE #	WORK PHONE #
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			
Section IV. CHILD CARE STAFF USE ONLY			
Child Care Responsibilities:	1. Medication named above was received 2. Medication labeled as required by COMAR 3. OCC 1214 Emergency Card updated 4. OCC 1215 Health Inventory updated 5. Modified Diet/Exercise Plan 6. Individualized Plan: IEP/IFSP 7. Staff approved to administer medication is available onsite, field trips		☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No
Reviewed by (printed name and signature):			DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE