

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (**applied to open wound/ broken skin**) _____

My child has previously taken this medication _____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date** _____

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply....

Plan was created by:

- Parent
- Doctor or Licensed Practitioner
- Program's Health Care Consultant
- Older school age child (9+ yrs. of age)
- Other: _____

Plan is maintained by:

- Director
- Assistant Director
- Child's Educator
- Other: _____

Name of child:	Date:
Any change to the child's Health Care Plan? YES (indicate changes below) NO (updated physician/parental signatures required)	
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

Food Allergy Action Plan

Student's

Name: _____ D.O.B: _____ Teacher: _____

Place
Child's
Picture
Here

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Thready pulse, low blood pressure, fainting, pale, blueness
- Other † _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication**:

- | | |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

To be
determined
by physician
authorizing
treatment

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1.) _____ 2.) _____
b. _____	1.) _____ 2.) _____
c. _____	1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____

Date _____

Doctor's Signature _____

(Required)

Date _____

TRAINED STAFF MEMBERS

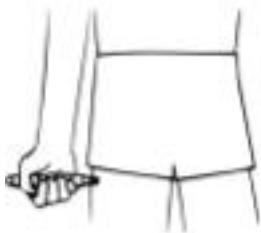
- | | |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

EPIPEN® AND EPIPEN® JR. DIRECTIONS

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.
- Once EpiPen® is used, call the Rescue Squad. State additional epinephrine may be needed. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.



***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

Asthma Action Plan



General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/Health Care Provider _____ Phone numbers _____

■ Physician Signature _____ Date _____

Severity Classification

- Mild Intermittent Moderate Persistent
 Mild Persistent Severe Persistent

Triggers

- Colds Smoke Weather
 Exercise Dust Air pollution
 Animals Food
 Other _____

Exercise

1. Pre-medication (how much and when) _____

2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
■ No cough or wheeze
■ Can work and play
■ Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
■ Cough, wheeze or chest tight
■ Problems working or playing
■ Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50 to 80% of personal best or
_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days
 Change your long-term control medicines by _____
 Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- Take quick-relief treatment again
 Change your long-term control medicines by _____
 Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
■ Cannot work or play
■ Getting worse instead of better
■ Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0 to 50% of personal best or
_____ to _____

Go to the hospital or call for an ambulance if

- Still in the red zone after 15 minutes
 If you have not been able to reach your physician/health care provider for help

Call an ambulance immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
 Lips or fingernails are blue