**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:** ____________

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**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: ____________________

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

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**
- **Physician Signature Date**

## Asthma Action Plan

### Severity Classification
- Mild Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Exercise</th>
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<tbody>
<tr>
<td>Colds</td>
<td>1. Pre-medication (how much and when)</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
</tr>
<tr>
<td>Dust</td>
<td>2. Exercise modifications</td>
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<tr>
<td>Weather</td>
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<tr>
<td>Animals</td>
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<tr>
<td>Food</td>
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<tr>
<td>Other</td>
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<td>Food</td>
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<tr>
<td>Weather</td>
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<tr>
<td>Air pollution</td>
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</tbody>
</table>

## Green Zone: Doing Well

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

### Peak Flow Meter
- More than 80% of personal best or ________

### Control Medications

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When To Take</th>
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## Yellow Zone: Getting Worse

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

### Peak Flow Meter
- Between 50 to 80% of personal best or __________ to __________

### Continue control medicines and add:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When To Take</th>
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**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

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

### Peak Flow Meter
- Between 0 to 50% of personal best or __________ to __________

### Continue control medicines and add:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When To Take</th>
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**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 fingertips are blue

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**Ambulance/Emergency Phone Number:**