CHILD HEALTH CONNECTION

MEDICATION AUTHORIZATION FORM

Child's Name:	Date of Birth:
Medication:	Dose:

The program will administer medication to children for whom a plan has been made and approved by the Director. Medication in the facility can present a safety hazard, parents should check with the child's health care provider to see if a dose schedule can be arranged to be administered at home. Parent/guardian may come to administer medication to their own child during the day.

Procedures for Medication in Licensed Child Care of Group Care Settings:

1. All medications or treatments require a health care provider and parent/guardian to complete and sign this form.
2. The program's Child Care Health Consultant will review this Medication Authorization Form and sign.
3. Over-the-counter medication must be the original container and labeled with the child's name. Prescription medication must have a pharmacy label that corresponds with the written order from the health care provider.
4. All medications will be stored out of the reach of children and returned to the parents once prescription is completed or medication has expired. Parents are responsible for providing measuring devices (for example, a syringe) for accurate medication administration.
5. All medication administrations will be recorded by the staff administering the medication.
6. **Children with conditions such as asthma, severe allergies, diabetes, oxygen, feeding tubes and seizure disorder require a detailed health care plan in addition to, or in lieu of, this Medication Authorization Form. Please see staff for a copy of a health care plan.**

Medications:

- Are administered in accordance with the pharmacy/medication label directions and as prescribed by the written instructions from the child's health care provider.
- The instructions from the child's parent/guardian shall not conflict with the label directions or as prescribed by the child's health care provider.
- Require a written prescription or completed Medication Authorization Form from the child's health care provider.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Parent statement: I have read the above policy and hereby authorize delegated staff to administer the prescribed medication to my child as designated on this form.

☐ By checking this box, I give permission for my child's health care provider to share information about the administration of this medication with the program's nurse or school staff delegated to administer medication.

Parent/Guardian name _____ Telephone _____

Parent/Guardian signature _____ Date _____

In case of emergency, please contact _____ Telephone _____

This portion completed by child's health care provider

Medication:	Dosage:	Route:
Time of Administration:	Start date:	End date:
Special Instructions:		
Purpose of Medication:		
Side effects to be reported:		

Signature of Health Care Provider _____ Date: _____

Printed Name of Health Care Provider _____ Phone/Fax: _____/_____

Child Care Health Consultant signature _____ Date: _____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG:	Short of breath, wheeze, repetitive cough
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Swelling of the tongue and/or lips
HEART:	Pale, blue, faint, weak pulse, dizzy
SKIN:	Many hives over body, widespread redness
GUT:	Vomiting or diarrhea (if severe or combined with other symptoms
OTHER:	Feeling something bad is about to happen, Confusion, agitation

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE:	Itchy, runny nose, sneezing
SKIN:	A few hives, mild itch
GUT:	Mild nausea/discomfort

→

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____