

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**

Place Child's Picture  
Here (optional)

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**

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	Name of Epinephrine Medication Call 911 Call Parent
<b>is Not exhibiting or complaining of any symptoms, OR</b>		
<b>Exhibits or complains of any symptoms below:</b>		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Throat*:</b> difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
<b>Lung*:</b> shortness of breath, repetitive coughing, wheezing		
<b>Heart*:</b> weak or fast pulse, low blood pressure, fainting, pale, blueness		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Other:</b>		
<b>If reaction is progressing (several of the above areas affected)</b>		

\*Potentially life threatening. The severity of symptoms can quickly change\*

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine Medication				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) Administer 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.

\*Emergency use epinephrine medication\* may include auto-injector(injectable) or non-injectable-nasal spray ready to use medication approved by FDA and prescribed by licensed health care provider.

PRESCRIBER'S NAME/TITLE	Place stamp here	
TELEPHONE	FAX	
ADDRESS		
<b>PRESCRIBER'S SIGNATURE</b> (Parent/guardian cannot sign here) (original signature or signature stamp only)		<b>DATE</b> (mm/dd/yyyy)

Maryland State Department of Education  
Office of Child Care  
**Allergy and Anaphylaxis**  
**Medication Administration Authorization Plan**

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	Yes	No
	2. Medication labeled as required by COMAR	Yes	No
	3. OCC 1214 Emergency Card updated	Yes	No
	4. OCC 1215 Health Inventory updated	Yes	No
	5. Modified Diet/Exercise Plan	Yes	No N/A
	6. Individualized Plan: IEP/IFSP	Yes	No N/A
	7. Staff approved to administer medication is available onsite, field trips	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