CYS SERVICES SNAP ALLERGY MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

Child's Name	Date of Birth	Date

Sponsor Name

Health Care Provider	Health Care Provider Phone

Allergies (please list)

_____

_____

Asthmatic □ Yes* □ No (*Higher risk for severe reaction)

Treatment Plan

If a food allergen has been ingested, but no symptoms: _ observe for symptoms _ Epinephrine _ Antihistamine _ Albuterol

Observe for Symptoms:

- Mouth — Itching, tingling or swelling of lips, tongue, mouth
- Skin — Hives, itchy rash, swelling of the face or extremities
- Stomach — Nausea, abdominal cramps, vomiting, diarrhea
- Throat* — Tightening of throat, hoarseness, hacking cough
- Lung* — Shortness of breath, repetitive coughing, wheezing
- Heart* — Weak or thready pulse, low blood pressure, fainting, pale, blueness
- Other* _____

(* Potentially life threatening; the severity of symptoms can quickly change)

Number order of Medication

_ Epinephrine _ Antihistamine _ Albuterol
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_Epinephrine _ Antihistamine _ Albuterol

Medication Protocol

Epinephrine: Inject into thigh (circle one): Epinephrine Autoinjector 0.3 mg 0.15 mg

May administer second dose of Epinephrine after 5 minutes if symptoms persist or worsen

Antihistamine: Give _____ as directed on prescription label
medication name

Albuterol: Give as directed on prescription label

May administer second dose of Albuterol after 15 minutes if symptoms persist or worsen

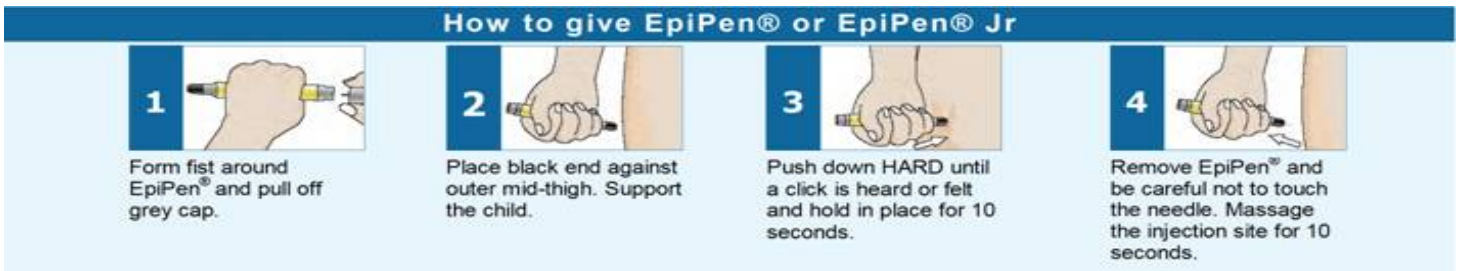
Other: Give _____
Medication/dose/route

Emergency Response

- Administer rescue medication as prescribed above
- Stay with child
- Contact parents/guardian

IF THIS HAPPENS ⇨
GET EMERGENCY HELP NOW!
CALL 911

- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips and fingernails are gray or blue



Form Updated 17Apr 09

Child's Name

ALLERGY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

Medications for Allergy

For children requiring rescue medication, the medication is required to be at program site at all times while child is in care. For youth who self-medicate and carry their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available.

Field Trip Procedures

Rescue medications should accompany child during any off-site activities.

- The child should remain with staff or parent/guardian during the entire field trip. □ Yes □ No
- Staff members on trip must be trained regarding rescue medication use and this health care plan. This plan must accompany the child on the field trip.
- Other (specify)_____

Self-Medication for School Age/Youth

□ YES. Youth can self-medicate. I have instructed _____in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. Youth has been instructed not to share medications and should youth violate these restrictions the privilege of self medicating will be revoked and the youth's parents notified. Youth are required to notify staff when carrying medication.

OR

□ NO. It is my professional opinion that _____SHOULD NOT carry or self administer his/her medication.

Bus Transportation should be alerted to child's condition.

- This child carries rescue medications on the bus. □ Yes □ No
- Rescue medications can be found in: □ Backpack □ Waistpack □ On Person □ Other_____
- Child should sit at the front of the bus. □ Yes □ No
- Other (specify): _____

Sports Events

Parents are responsible for having rescue medication on hand and administering it when necessary when the child is participating in any CYS sports activity. Volunteer coaches do not administer medications.

Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the CYS nurse/APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child must have required medication with him/her at all times when in attendance at CYS programs.

Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying medication.

Follow Up

This Allergy Medical Action Plan will be updated/revised whenever medications or child's health status changes. If there are no changes, the Allergy Medical Action Plan will be updated at least every 12 months.

Printed Name of Parent/Guardian	Parent Signature	Date (YYYYMMDD)
Printed Name of Youth (if applicable)	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)