Child Care Medication Authorization Form

Each medication needs a separate Medication Authorization Form, each signed by the child's health care provider.

Name of Child:_____D.O.B.:_____Today's Date:_____

Name of Medication:_____

Reason for Medication:_____

Dose:_____Time/Frequency: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other

Date to Start:_____Date to stop:_____Expiration:_____

Additional Instructions/Comments: _____

_____

Known side effects:_____

_____

SIGNATURE OF HEALTH CARE PROVIDER

Prescribing Health Care Provider:_____

Date: _____ Phone Number: _____

I authorize **Child Priority Preschool** personnel to administer the medication named above to my child in the manner as stated. All prescriptions and "over-the-counter" medications I give the school must be new, unopened, and in the original bottle or box. I must immediately tell Child Priority Preschool about any change in my child's medicine or the health care provider's instructions. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions. This Medication Authorization Form expires at the end of the school year.

Parent/guardian printed name: _____**Date Signed:** _____

Parent/guardian signature: _____

FOR CHILD PRIORITY PRESCHOOL USE ONLY

Amount of Medication Received:_____

Director Signature:_____Date: _____

RETURN OR DISPOSAL

Return / Disposal Date: _____ Witness to Disposal: _____

Director Signature: _____

Attach student photo here

EPI-PEN / BENADRYL USE FOR ALLERGIES & ANAPHYLAXIS

Please return to Child Priority Preschool Director.

Student Last Name: _____ First Name: _____ Middle_____ Date of birth: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies: ☐ Allergy to: _____ ☐ Allergy to: _____ ☐ Allergy to: _____ ☐ Allergy to: _____

History of asthma? ◯ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma Care Plan for this student) ◯ No

History of anaphylaxis? ◯ Yes Date: _____ ◯ No

If yes, system affected ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic

Treatment: _____ Date: _____

Does this student have the ability to:

Self-Manage (See 'Student Skill Level' below)	◯ Yes	◯ No
Recognize signs of allergic reactions	◯ Yes	◯ No
Recognize and avoid allergens independently	◯ Yes	◯ No

Select In-School Medications

SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

◯ 0.15 mg ◯ 0.3 mg

Give intramuscularly in the anterolateral thigh for any of the following signs/symptoms (retractable devices preferred) :

- Shortness of breath, wheezing, or coughing
- Fainting or dizziness
- Lip or tongue swelling that bothers breathing
- Pale or bluish skin color
- Tight or hoarse throat
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Weak pulse
- Trouble breathing or swallowing
- Feeling of doom, confusion, altered consciousness or agitation
- Many hives or redness over body

☐ Other: _____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____

Even if child has MILD signs/symptoms after a sting or eating these foods, give epinephrine.

B. If no improvement, or if signs/symptoms recur, repeat in minutes for maximum of times (not to exceed a total of 3 doses)

☐ If this box is checked, give antihistamine after epinephrine administration (order antihistamine below)

MILD REACTION

A. Give antihistamine: Name: _____ Preparation/Concentration: _____Dose: _____ Route:_____

Frequency: ◯ Q4 hours or ◯ Q6 hours as needed for any of the following signs/symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other:_____

ADDITIONAL HEALTH CARE PROVIDER INSTRUCTIONS:

_____

_____

_____

Health Care Provider

Last Name (Print):_____ First Name (Print): _____ Signature: _____

License # (Required): _____ NPI #: _____ **Please check one:** ☐ MD ☐ DO ☐ NP ☐ PA Date: _____

Address: _____ E-mail address: _____

Tel: _____ Cell Phone: _____

Parent / Guardian

I authorize Child Priority Preschool personnel to administer the medication named above to my child in the manner as stated. All prescriptions and "over-the-counter" medications I give the school must be new, unopened, and in the original bottle or box. I must immediately tell Child Priority Preschool about any change in my child's medicine or the health care provider's instructions. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions. This Epi-pen / Bendaryl Use for Allergies & Anaphylaxis Form expires at the end of the school year.

Parent/guardian printed name: _____**Date Signed:** _____

Parent/guardian signature: _____

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware ***911 may be called if a quick relief inhaler is not at school*** and my child/youth is experiencing symptoms.

Parent/Guardian Signature _____ **Date** _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other**: _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

IF YOU SEE THIS:		DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature _____ **Print Provider Name** _____ **Date** _____

Good for 12 months unless specified otherwise in district policy.

Fax _____ **Phone** _____ **Email** _____

School Nurse/CCHC Signature _____ **Date** _____

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021