School Age Adventures
Right in Your Neighborhood School

Medication Requirements

Your child's registration packet indicates that he or she may require medication to be dispensed while at our program. In order for us to comply with New Hampshire Licensing requirements, **you must provide the items listed below prior to your child's first day of attendance at our program.**

Non-Prescription Medications

If your child requires any non-prescription medication to be dispensed during our program hours you must provide the following:

1) The medication in its original container.

2) A "Medication Authorization" form (attached) granting permission for our staff to dispense the required medication during program hours, signed by the child's parent/guardian.

3) All items must be placed in a labeled Ziploc bag and provided to our office at 4 Lake Street, Nashua, NH before the first day your child is scheduled to attend the program.

Your child cannot attend the program if the required items are not provided.

Our program staff do not have access to any medication being held in the school nurse's office during our program hours.

Prescription Medications

If your child requires any prescription medication to be dispensed during our program hours you must provide the following:

1) The medication in its original container, with attached prescription label. The label must include the child's name, medication name, strength, prescribed dose and method of administration.

2) If you do not have the prescription label, a Medication Order provided and signed by your child's licensed health care provider is required and must include the child's name, medication name, strength, prescribed dose and method of administration, frequency of administration, indications for usage, maximum dosage allowed in a 24 hour period and any special precautions or limitations regarding administration of the medication.

3) A "Medication Authorization" form (attached) granting permission for our staff to dispense the required medication during program hours, signed by the child's parent/guardian and licensed health care provider.

(PLEASE CONTINUE ON BACK)

4) All items must be placed in a labeled Ziploc bag and provided to our office at 4 Lake Street, Nashua, NH before the first day your child is scheduled to attend the program.

Your child cannot attend the program if the required items are not provided.

Our program staff do not have access to any medication being held in the school nurse's office during our program hours.

Allergy Medication

If your child has an allergy requiring medication to be dispensed during our program hours you must provide the following:

1) The medication in its original container, with attached prescription label. The label must include the child's name, medication name, strength, prescribed dose and method of administration.

2) If you do not have the prescription label, a Medication Order provided and signed by your child's licensed health care provider is required and must include the child's name, medication name, strength, prescribed dose and method of administration, frequency of administration, indications for usage, maximum dosage allowed in a 24 hour period and any special precautions or limitations regarding administration of the medication.

3) A "Medication Authorization" form (attached) granting permission for our staff to dispense the required medication during program hours, signed by the child's parent and/or Guardian and licensed health care provider.

4) An "Allergy Action Plan" (enclosed orange form) completed with photo, dated and signed by both your child's licensed health care provider and the parent/guardian.

5) All items must be placed in a labeled Ziploc bag and provided to our office at 4 Lake Street, Nashua, NH before the first day your child is scheduled to attend the program.

Your child cannot attend the program if the required items are not provided.

Our program staff do not have access to any medication being held in the school nurse's office during our program hours.

IF YOUR CHILD'S MEDICAL RECORDS INDICATE THEY REQUIRE MEDICATION DURING OUR PROGRAM HOURS AND YOU DO NOT WISH TO PROVIDE THE MEDICATION FOR OUR STAFF YOU MUST FILL OUT THE ATTACHED "MEDICATION RELEASE FORM".

Allergy Action Plan

Place Child's Picture Here

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.

Give Checked Medication**:

**(To be determined by physician authorizing treatment)

☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
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☐ Epinephrine ☐ Antihistamine

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆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. _____ Phone Number: _____ at _____

3. Parents_____ Phone Number(s)_____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	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_____ Date_____
(Required)

TRAINED STAFF MEMBERS

1. _____ Room _____

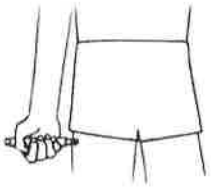
2. _____ Room _____

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.**

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- **Pull off green end cap, then red end cap.**

- **Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.**

<u>SECOND DOSE ADMINISTRATION</u>:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow or orange collar off plunger.**

- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject™ is used, call the Rescue Squad. 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.

The Food Allergy & Anaphylaxis Network

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.18, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION.

PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

NON-PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILD'S LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT ______________________________ TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

FOLLOWING MEDICATION TO MY CHILD: ______________________________ ______________
CHILD'S NAME DATE OF BIRTH

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE

____
PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER

______________________________ ______________
PARENT/GUARDIAN'S SIGNATURE **DATE SIGNED**

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

THE ABOVE SPECIAL INSTRUCTIONS WERE:
- ☐ **REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER**
- ☐ **COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW**

______________________________ ______________
LICENSED HEALTH PRACTITIONER'S SIGNATURE **DATE SIGNED**

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

______________________________ ______________
SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION/CONTROL OF MEDICATION DATE SIGNED

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Medication Release Form

Date: _____

Dear Parent:

Your child's health record indicates _____ has
(Child's Name)

_____; therefore medication
(Condition)

is required in case of emergency. You have not given us the medication for your child if it is needed. Please sign below indicating you will accept full responsibility in case of emergency.

_____ _____
Signature Date

_____
Print Name

ALC
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