

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: | | Number order of Medication |
|------------------------------|---|--|
| ▪ Mouth | Itching, tingling or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Skin | Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Stomach | Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Throat* | Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Lung* | Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Heart* | Weak or thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |
| ▪ Other* | _____ | <input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol |

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

Medication Protocol

Epinephrine: Inject into thigh (circle one): EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: Give _____ as directed on prescription label

Albuterol: Give _____ as directed on prescription label may repeat do not repeat

Other: Give _____





Medication/dose/route

Emergency Response

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

| | |
|---|--|
| <h2 style="margin: 0;">IF THIS HAPPENS GET EMERGENCY HELP NOW! CALL 911</h2> | <ul style="list-style-type: none"> Epi Pen is administered Hard time breathing with: <ul style="list-style-type: none"> 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 |
|---|--|

How to give EpiPen® or EpiPen® Jr

| | | | |
|--|--|--|--|
| <div style="background-color: #0056b3; color: white; padding: 5px; font-weight: bold; font-size: 24px;">1</div>  <p style="font-size: small;">Form fist around EpiPen® and pull off grey cap.</p> | <div style="background-color: #0056b3; color: white; padding: 5px; font-weight: bold; font-size: 24px;">2</div>  <p style="font-size: small;">Place black end against outer mid-thigh. Support the child.</p> | <div style="background-color: #0056b3; color: white; padding: 5px; font-weight: bold; font-size: 24px;">3</div>  <p style="font-size: small;">Push down HARD until a click is heard or felt and hold in place for 10 seconds.</p> | <div style="background-color: #0056b3; color: white; padding: 5px; font-weight: bold; font-size: 24px;">4</div>  <p style="font-size: small;">Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.</p> |
|--|--|--|--|

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/Instructional Programs

Parents are responsible for having rescue medication on hand and administering it when necessary when the child is participating in any CYS sports/Instructional activity. Volunteer coaches/instructors 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 | Amy Public Health Nurse Signature (This signature serves as the exception to medication policy) | Date (YYYYMMDD) |