Medfield Afterschool Program

SEVERE ALLERGY ACTION PLAN

Attach Photo

USE THIS FORM FOR: All severe allergies which may require emergency medication such as an antihistamine and/or epinephrine.
Please contact your child's program director to set up a time to drop off required medication(s), provide information, training, and review all forms.
Plan must be renewed annually and updated when/if child's condition changes.

Name of Child: _____ Grade: _____ Date of Birth: _____

Parent/Guardian: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Parent/Guardian: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

ALLERGY: _____

ASTHMATIC: ☐ No ☐ Yes (Please attach a copy of your child's Asthma Action Plan - Higher risk for severe reaction)

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Shortness of breath, repetitive coughing, wheezing
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (eyes, lips)
GUT: Vomiting, crampy pain

1. INJECT EPINEPHRINE IMMEDIATELY
2. CALL 9-911 (FROM MAP)
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/ bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis) USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around the mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professional and parent
3. If symptoms progress (see above), USE EPINEPHRINE.
4. Begin monitoring (see box below)

MEDICATION: Epinephrine (brand): _____ (dose):_____

Antihistamine (brand): _____ (dose):_____

Other (inhaler-bronchodilator if asthmatic) (brand): _____ (dose):_____

Potential side effects of the treatment? _____

Potential consequences if treatment is not administered? _____

MONITORING – Stay with child; alert healthcare professionals & parent/guardian. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first symptoms persist or recur. For a severe reaction, consider keeping the child lying on back with legs raised. Treat student even if parent/guardian cannot be reached.

I, _____, the parent/guardian, will provide the MAP Staff with training that specifically addresses the child's allergy, medication(s), and other treatment needs. I give permission for MAP to administer the above treatment, including the administration of the medication(s) specified.

Licensed Health Care Practitioner's Signature: _____ Date: _____

Printed Name of Practitioner: _____ Office Phone: _____

Parent's/Guardian's Signature: _____ Date: _____

Medfield Afterschool Program

SEVERE ALLERGY ACTION PLAN
MEDICATION CONSENT FORM

(only one medication per form in original container)

To be filled out on the child's last day
Date returned:_____

Parent/Guardian Signature:

_____

To be filled out by child's parent/guardian:

Name of Child: _____ Allergy: _____

Name of Medication:_____ (one medication per form) ☐ Prescription ☐ Non-Prescription

Type of Medication: ☐ Injection ☐ Liquid ☐ Pill (# Pills if prescription ____) ☐ Other _____

Storage Directions: _____

Dosage _____ (must match what the Licensed Health Care Practitioner authorized on the Severe Allergy Action Plan)

Date of 1st Dose _____ (MAP cannot administer the 1st dose of any medication unless it is an emergency medication such as epinephrine)

Does the child have the same medication or other medications at school that may be administered before they arrive at MAP and that would require the MAP staff to know when it was last taken? ☐ **YES** ☐ **NO** **IF YES** do you give your child's school nurse permission to contact MAP and/or for MAP to contact the nurse to see if any such medication was administered during the child's school day? ☐ **YES** ☐ **NO**

I have submitted to MAP their completed "Severe Allergy Action Plan" that was signed by the child's licensed health care practitioner and parent/guardian. I authorize MAP educators to administer medication to my child as indicated on the signed "Severe Allergy Action Plan".

Parent/Guardian Signature: _____ **Date: _____**

COMPLETED BY MAP STAFF: **MEDICATION ADMINISTRATION RECORD**

☐ Who trained the staff: _____ ☐ Medication Consent Form Completed

☐ Original prescription label on the medicine container ☐ Name of the child on the container

☐ Date on prescription current (good for 1 year from date prescription filled) ☐ Expiration Date _____

☐ Dose, name of drug, frequency of administration given on the label match parent/guardian instructions

☐ 5 rights addressed (right child, right medication, right does, right route & right time)

CHILD'S NAME: _____ **MEDICATION:** _____

Date	Time	Medication	Dose	Route	Staff Signature	Miss dose Errors	Child Refusal (✓)

If child refused medication, explain why and attach to administration record.

This record must be maintained in the child's file when complete

JS- K-1 Program (508) 359-2165
Meghan.map@comcast.net

2-3 Program (508) 359-8513
Alex.23map@gmail.com

MAP @ Pfaff Program (508) 359-2168
kurt14.map@gmail.com

Please complete a Medication Consent Form for *each* medication

Medfield Afterschool Program, Inc.

Health History, Training & Program Considerations

To be filled out by Program Director/Lead Educator during the parent/guardian meeting and attached to the severe allergy action plan or individual health care plan.

Please contact your child's Program Director once you have all of the forms completed, including the signature of a licensed health care practitioner, and required medication (if any) in the original box. This meeting is required prior to your child's attendance at MAP.

Meghan Jackson
JS- K-1 Program (508) 359-2165
Meghan.map@comcast.net

Alex Sakash
2-3 Program (508) 359-8513
Alex.23map@gmail.com

Kurt Jackson
MAP @ Pfaff Program (508) 359-2168
kurt14.map@gmail.com

Child's Name: _____ *Program:* _____

*Date of Meeting:*_____ *Parent Guardian:* _____

Training:

Severe Allergy: Has your child ever needed to have an epinephrine injection or inhaler? _____How many times? _____

Other Emergency Medication: _____

Last time used:_____ For What Symptoms: _____

Does your child need to ingest the allergen to have a reaction? _____

Does your child require special seating when having snack or lunch? _____

Will you be sending in special snacks? _____

Information and special considerations for when the child is in MAP's care:_____

_____

_____

_____

_____

_____

Individual Health Care Plan: Information and special considerations for when the child is in MAP's care: _____

_____

_____

_____

_____

_____

_____

_____

_____

Program Director/Lead Educator Signature: _____ Date: _____