



**Written Medication Consent Form**

**PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)**

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?)  Yes  N/A  No  
Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm): \_\_\_\_\_

20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to \_\_\_\_\_  
(child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:
---	----------------------

23. Parent or legal guardian's signature:

**CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)**

24. Provider/Facility name:	25. Facility telephone number:	26. (leave blank)
-----------------------------	--------------------------------	-------------------

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.

28. Authorized child care provider's name (please print):	29. Date received from parent:
---	--------------------------------

30. Authorized child care provider's signature:

**ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15**

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on \_\_\_\_\_  
(date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)**

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. \_\_\_\_\_

34. Licensed Authorized Prescriber's Signature:

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.  
DATE: \_\_\_\_\_

By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** \_\_\_\_\_








THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:





## SEVERE SYMPTOMS

 <b>LUNG</b> Short of breath, wheezing, repetitive cough	 <b>HEART</b> Pale, blue, faint, weak pulse, dizzy	 <b>THROAT</b> Tight, hoarse, trouble breathing/swallowing	 <b>MOUTH</b> Significant swelling of the tongue and/or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

↓ ↓ ↓

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy/runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea/discomfort
---	--	--	---

---

**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

---

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

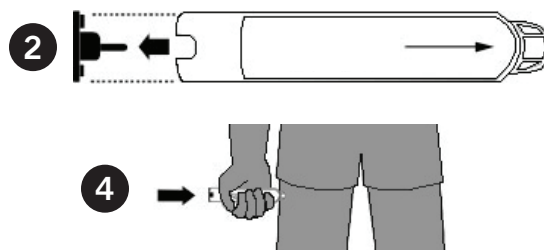
Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ PHYSICIAN/HCP AUTHORIZATION SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

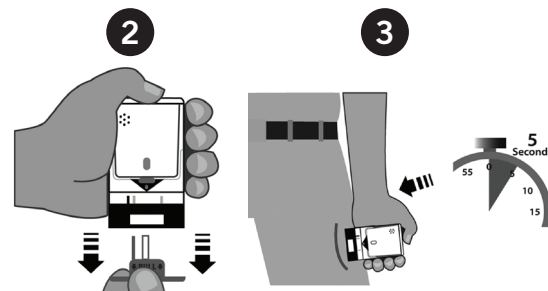
## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



## AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



## ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_