EMERGENCY HEALTH CARE PLAN

AL GY TO: _____

Child's Name: _____ DOB: _____ Child Care Provider_____

History of Asthma Yes (high risk for severe reaction) No

Signs of an allergic reaction include:

Systems	Symptoms
MOUTH	Itching & swelling of lips, tongue, or mouth
*THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
*LUNG	Shortness of breath, repetitive coughing, and/or wheezing
*HEART	"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:
If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)

_____ Observe child for severe symptoms
_____ Administer EpiPen® before symptoms occur
_____ Administer EpiPen® if symptoms occur
__ _____ Administer Benadryl® (dose)_____ or Atarax® (dose) _____
__ _____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
_____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!

_____ _____ _____ _____
Parent Signature Date Prescriber Signature MD/APRN/PA Date

_____
Address Phone

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____	1. _____ Room_____
Relation: _____ Phone _____	
2. _____	2. _____ Room_____
Relation: _____ Phone _____	
3. _____	3. _____ Room_____
Relation: _____ Phone	

For children with multiple allergies, use one form for each allergen

WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER; PARENT'S PERMISSION for an Emergency Medication

If a Child Day Care Center, A Group Day Care Home or a Family Day Care Home chooses to administer medications, the Connecticut State Law and Regulations require a physician's, dentist's or advanced practice registered nurses' written order and parent or guardian's authorizations for a nurse, the director, teacher or day care provider to administer medications. Medications must be in the original pharmacy prepared containers and labeled with the name of child, name of drug, strength, dosage, frequency, name of prescriber, and date of original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN, DENTIST, ADVANCED PRACTICE REGISTERED NURSE OR PHYSICIAN ASSISTANT

1. Name of Child _____ Date of Birth _____

Address _____

Condition for which **medication** is being administered during day care hours: _____

2. Medication: _____ Date of Order: _____

3. Dose _____ **4. Route:** _____ **5. Time:** _____

Medication shall be administered from _____ to _____
Date Date

Side effects to be observed, if any: _____ ☐ see package insert

Plan for management of side effects: ☐ call parent ☐ call health care provider ☐ other _____

Is this a controlled medication? _____ Allergies to food or medications? If yes, list _____

Interaction of medication with food: _____

Name of **Licensed** Prescriber _____ Telephone _____
(Type or print)

Address _____ **Licensed** Prescriber signature _____

Authorization by Parent/Guardian for the administration of the above medication: Date: _____

I hereby request that the above medication, ordered by the physician/dentist/advanced practice registered nurse for my child _____, be administered by the nurse, director, or teacher. ~~I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions.~~ I understand that I must supply the Child Day Care Center, Group Day Care Home or Family Day Care Home with the prescribed medication on the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

I authorize my child care provider/program to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects.: ☐ YES ☐ NO

Name **Parent/ Guardian** _____ Signature _____
(Type or print)

Address: _____

Relationship to Child _____ Telephone _____

For Controlled substances, child care and parent must fill out following:
Amount/Quantity Received: _____
Child Care Provider signature/date: _____

Parent/Guardian signature/date: _____

Signature of Certified Child Care Provider receiving and reviewing this form:

_____