ACKNOWLEDGMENT OF ALLERGIES/MEDICAL CONDITIONS
(only sign if applicable)

Child's Name _____

Program Location _____

I acknowledge that allergies and/or medical conditions are listed on my child's *Health Inventory* and/or *Emergency Form*, that I represented to Anne Arundel County and the Department of Recreation and Parks that my child has no medications that he or she is taking or needs to have available while attending the Recreation & Parks program, and that I have provided Recreation & Parks with no medications or equipment to treat those conditions.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (Please print name clearly on this line)

Revised 07/2011

PERMISSION TO APPLY OVER-THE-COUNTER CREAMS AND OINTMENTS

This form is to be used for over-the-counter topicals only. (Any prescription creams, lotion, ointment, etc. still requires the Medication Authorization Form completed and submitted). Children are expected to apply these topicals. The County assumes no liability and the parent(s), on behalf of themselves and their minor child, hereby holds the County harmless and waives any and all claims for personal injury to the minor child as the result of the application or failure to apply any cream/ointment for the minor child by any County employee or volunteer.

This form is to be used for non-medicated sunscreen, lip balm, Vaseline, lotions, creams, ointments, etc that are to be applied to external areas only. Siblings may not share. **Any cream, lotion, ointment, etc. must be provided by the parent and labeled in permanent marker with the child's name. It must also have already been applied prior at home with no adverse effects to the child (i.e. rash, irritation, or other reaction).** Please list all tropical medication separately.

Child's Name _____ Date of Birth _____

Parent or Guardian _____

Home Phone Number _____ Cell Phone Number _____

1. _____ Type of Topical
   and Brand Name Area of Body to be Applied

2. _____ Type of Topical
   and Brand Name Area of Body to be Applied

3. _____ Type of Topical
   and Brand Name Area of Body to be Applied

My child has previously used the above product(s) with no adverse reaction(s).

_____

PARENT OR GUARDIAN SIGNATURE DATE

FOR SUNSCREEN ONLY:

Children will be expected to apply their own sunscreen. Please practice this at home.
Staff may assist with hard to reach areas with your signed permission only.

_____

PARENT OR GUARDIAN SIGNATURE DATE

Revised 4/17

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child's Picture

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions: _____

Medication shall be administered from: _____ to _____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date

Maryland State Child Care/Nursery School
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

Triggers (list)

_____
_____
_____
_____
_____
_____
_____

Student's

Name:_____ DOB:_____ PEAK FLOW PERSONAL BEST:_____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: _____ ☐ Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency
☐ Prior to exercise/sports/ physical education	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Quick Relief Medications — to be added to Green zone medications for symptoms

☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: _____	Medication	Dose	Route	Frequency
☐ Peak flow between _____ and _____ (50%-79% personal best)	If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

RED ZONE: Emergency Medications— Take these medications and call 911

☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or skin retracts between ribs ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Other:_____ ☐ Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency
	Contact the parent/guardian after calling 911.			

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. By signing below, I authorize to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs. Student may self-carry medications:

[School-age children) ❑Yes ❑No

Prescriber signature: _____ Date: _____ Parent / Guardian Signature: _____ Date: _____

Reviewed by Child Care Provider: Name: _____ Signature: _____ Date: _____

3/20/2014

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*__IMPORTANT:__ Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

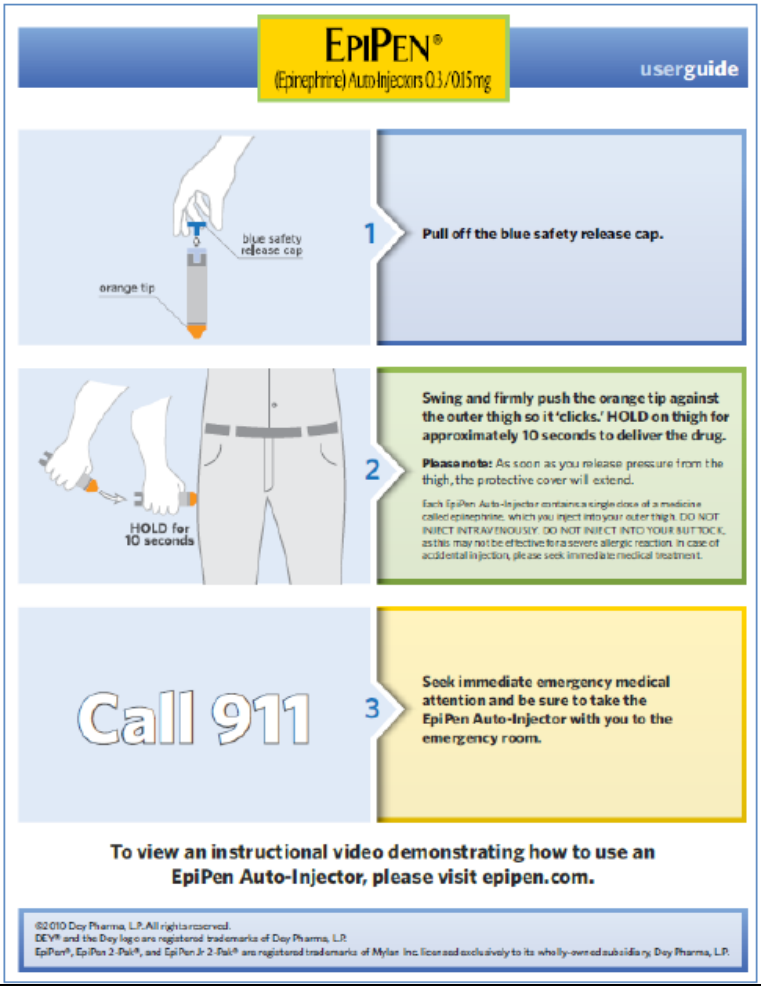
CHILD'S NAME: _____ **Date of Birth**: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure Medication Administration Authorization Form

Name of Child Care Facility _____

This form authorizes emergency seizure care for _____ ❒ M ❒ F
(Child's Name) **(Date of Birth)**
while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician _____ Phone#_____ # After Hours_____

Significant Medical History: _____

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Seizure Emergency Protocol (Check all that apply and clarify below)

❒ Call 911 for transport to _____ ❒ Notify parent or emergency contact

❒ Notify treating physician _____ ❒ Other_____

❒ Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure? ❒ **Yes** ❒ **No** If YES, describe process for returning the child to the classroom. _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____
_____

Physician Signature: _____ **Date:** _____

Parent Information & Authorization: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

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