

## **ACTION PLAN**

**(To be completed by pediatric health professional and signed by parent)**

**Date:**

**Child's Name:**

**Medical condition(s) of concern:**

**Signs or symptoms to watch for: Treatment or Modification of Environment:**

Note: When possible, please reduce or eliminate medication administration in the child care setting

Medication(s) (if applicable)			
Dosage(s)			
Time(s) of Administration			
Dates of Administration			
Possible Side Effects			

\_\_\_\_\_  
**Pediatric Health Professional Signature**

\_\_\_\_\_  
**Phone**

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I hereby give permission for the child care provider to administer medication as prescribed above. I also give permission for the child care provider to contact the prescribing pediatric health professional regarding the administration of this medication if there are problems or questions.

\_\_\_\_\_  
**Parent or Guardian Name (Print)**

X

\_\_\_\_\_  
**Parent/Guardian Signature**

If the recommended steps above do not help my child, please call me immediately. If you cannot reach me in a timely manner, please activate the emergency medical services.

Parent/Guardian Contact Info:

\_\_\_\_\_  
**Home Phone  
Pager**

**Work Phone**

**Cell Phone**

As the parent/guardian, I will, in writing, keep the program informed of any change to my phone numbers.

\_\_\_\_\_  
Parent/Guardian Signature

## RELEASE OF LIABILITY

**I hereby release and forever discharge** Child Development and Youth Programs and its employees or agents from any and all liability arising in law or equity as a result of administering any medication or treatment authorized above. This waiver and release of liability includes, but is not limited to, claims, actions, expenses, damages, injury, death, loss or damage to material and/or equipment supplied by the parent(s)/guardian(s), in any way relating to the administration of medication or treatment.

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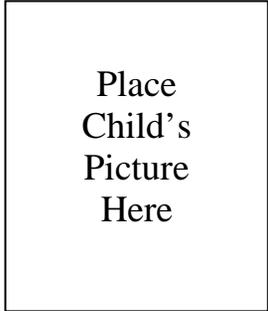
Parent/Guardian Signature

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Date

# Food Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_



ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> <small>** (To be determined by physician authorizing treatment)</small>
▪ If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Mouth    Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Skin      Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Gut        Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Throat†   Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Lung†     Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Heart†    Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Other†    _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Parent \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

4. Emergency contacts:  
Name/Relationship \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)

## TRAINED STAFF MEMBERS

1. \_\_\_\_\_

Room \_\_\_\_\_

2. \_\_\_\_\_

Room \_\_\_\_\_

3. \_\_\_\_\_

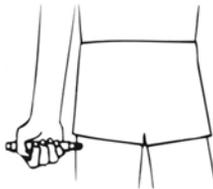
Room \_\_\_\_\_

### EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

### Twinject® 0.3 mg and Twinject® 0.15 mg Directions



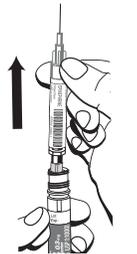
- Remove caps labeled "1" and "2."
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



### SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
- Slide yellow collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

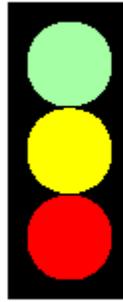
For children with multiple food allergies, consider providing separate Action Plans for different foods.

*\*\*Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*



# Asthma Action Plan see attached DD Form 2005 for Privacy Act Statement

**Patient Identification:**



The colors of a traffic light will help You use your asthma medicine.

**Green means Go Zone!**  
Use controller medicine.

**Yellow means Caution Zone!**  
Add quick-relief medicine.

**Red means Danger Zone!**  
Get help from a doctor.

**Personal Best Peak Flow:** \_\_\_\_\_

**GO – You're Doing Well! ➡ Use these daily controller medicines:**

**You have all of these:**

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play



Peak flow from \_\_\_\_\_ to \_\_\_\_\_

Medicine/Route	How Much	How Often/When

Before exercise or extreme weather:

Albuterol with spacer \_\_\_\_\_  2 or  4 puffs 20-30 minutes prior.

**CAUTION – Slow Down! ➡ Continue with green zone medicine and add:**

**10 DAYS TREATMENT**

**You have any of these:**

- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing, wheezing, or trouble breathing at night



Peak flow from \_\_\_\_\_ to \_\_\_\_\_

Medicine/Route	How Much	How Often/When

**DANGER – Get Help! ➡ Take these medicines and call your doctor now.**

**Your asthma is getting worse fast:**

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well



Peak flow from \_\_\_\_\_ to \_\_\_\_\_

Medicine/Route	How Much	How Often/When

Asthma Severity Level: \_\_\_\_ Mild Intermittent \_\_\_\_ Mild Persistent \_\_\_\_ Moderate Persistent \_\_\_\_ Severe Persistent

Comments: Get flu shot yearly, avoid exposure to smoke, take medicine as instructed to prevent asthma attacks

Prepared By (Signature & Title)	Department/Service/Clinic	Date
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**NAVY CHILD AND YOUTH PROGRAMS  
MEDICATION ADMINISTRATION FORM**

REQUIRING DIRECTIVE OPNAVINST 1700.9

**NAVY CYP MEDICATION ADMINISTRATION FORM**

It is preferable that medication not be administered within the CYP Programs. When possible, parents and physicians should adjust medication schedules so that the program staff are not responsible for administration. We recognize that this is not always possible and we will agree to administer any medication as follows:

- ✓ Written orders by a physician must be on file in order to administer any medication.
- ✓ Parent/legal guardian must sign the liability release.
- ✓ Child shall be monitored on the medication for 24 hours each time medication is prescribed before the program staff administers medication.
- ✓ Children who need medications administered for extended time periods, or that have special health concerns will be required to complete Special Needs paperwork and be reviewed by the special needs review board.

**ALL INFORMATION IN THIS SECTION MUST BE COMPLETED LEGIBLY BY A PHYSICIAN**

\_\_\_\_\_  
**Name of Child**

\_\_\_\_\_  
**Name of Medication to be Administered by CYP Staff**

\_\_\_\_\_  
**Time of Day and/or Frequency Medication is to be Administered**

\_\_\_\_\_  
**Duration of Medication (Dates)**

\_\_\_\_\_  
**Any Known Allergies**

**Can this medication schedule be adjusted so the medication is administered outside the CYP hours only?**  YES  NO

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date of Order**

**PARENTAL CONSENT/WAIVER/RELEASE AND INDEMNIFICATION**

I hereby give consent for the CYP staff to administer medication to my child as directed above by the physician. I agree to indemnify and hold harmless Navy Child and Youth Programs, MWR, a non-appropriated fund instrumentality of the United States Navy, and any other instrumentality of the United States, and their officers, agents, and employees from any losses, expense, damage, claim, suit, or judgment arising out of or resulting from administration of medication to my child. As the parent/legal guardian, I agree to assume all risk associated with administration of medication including inadequacy or failure of staff and I also assure the said medication is safe for my child.

\_\_\_\_\_  
(Print) Parent Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date