NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM
CHILD DAY CARE PROGRAMS

PARENT 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 licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name)*:

21. Parent's Name *(please print)*:	22. Date Authorized:

23. Parent's Signature:

X

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

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:
St. Luke Preschool	414911	631-462-5216

27. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent:

30. Staff Signature:

X

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

31. I, parent, 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 Signature:

X

Food Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ **D.O.B:** _____ **Teacher:** _____
Allergy to: _____ **Asthmatic:** Yes* ☐ No ☐ *Higher risk for severe reaction

■ STEP 1: TREATMENT ■

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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one, and see reverse side for instructions)
EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Adrenaclick™ 0.3 mg Adrenaclick™ 0.15 mg
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:
   a. Name/Relationship _____ Phone Number: _____
   b. Name/Relationship _____ Phone Number: _____

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)

Staff Members Trained in Epinephrine Administration: