

Maryland State Department of Education  
Office of Child Care

**Allergy and Anaphylaxis  
Medication Administration Authorization Plan**



This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. **This authorization is NOT TO EXCEED 1 YEAR.**  
**Page 1 to be completed by the Authorized Health Care Provider.**  
**FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216**

CHILD'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of plan: \_\_\_\_\_  
 Child has Allergy to \_\_\_\_\_  Ingestion/Mouth  Inhalation  Skin Contact  Sting  Other \_\_\_\_\_  
 Child has had anaphylaxis:  Yes  No  
 Child has asthma:  Yes  No (If yes, higher chance severe reaction) Child  
 may self-carry medication:  Yes  No  
 Child may self-administer medication:  Yes  No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth <input type="checkbox"/> Call Parent <input type="checkbox"/> Call 911	Epinephrine(EpiPen) IM Injection in Thigh <input type="checkbox"/> Call 911 <input type="checkbox"/> Call Parent
<b>is Not exhibiting or complaining of any symptoms, OR</b>		
<b>Exhibits or complains of any symptoms below:</b>		
<b>Mouth:</b> itching, tingling, swelling of lips, tongue ("mouth feels funny")		
<b>Skin:</b> hives, itchy rash, swelling of the face or extremities		
<b>Throat*:</b> difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
<b>Lung*:</b> shortness of breath, repetitive coughing, wheezing		
<b>Heart*:</b> weak or fast pulse, low blood pressure, fainting, pale, blueness		
<b>Gut:</b> nausea, abdominal cramps, vomiting, diarrhea		
<b>Other:</b>		
<b>If reaction is progressing (several of the above areas affected)</b>		

\*Potentially life threatening. The severity of symptoms can quickly change\*

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

**EMERGENCY Response:**

- 1) Inject epinephrine right away! Note time when epinephrine was administered.
- 2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
- 3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
- 4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
- 5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE	Place stamp here		
TELEPHONE	FAX		
ADDRESS			
PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)		DATE (mm/dd/yyyy)	

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Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.

PARENT/GUARDIAN SIGNATURE		DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #		HOME PHONE #	WORK PHONE #
Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency	
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

**Section IV. CHILD CARE STAFF USE ONLY**

- |                              |   |   |
|------------------------------|---|---|
| Child Care Responsibilities: | 1. Medication named above was received                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
|                              | 2. Medication labeled as required by COMAR                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
|                              | 3. OCC 1214 Emergency Card updated  | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
|                              | 4. OCC 1215 Health Inventory updated  | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |
|                              | 5. Modified Diet/Exercise Plan  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
|                              | 6. Individualized Plan: IEP/IFSP  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
|                              | 7. Staff approved to administer medication is available onsite, field trips | <input type="checkbox"/> Yes <input type="checkbox"/> No                              |

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)
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**DOCUMENT MEDICATION ADMINISTRATION HERE**

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE