

# CYS SERVICES SNAP ALLERGY MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

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

Health Care Provider	Health Care Provider Phone
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**Allergies (please list)**

\_\_\_\_\_ Asthmatic  Yes\*  No (\*Higher risk for severe reaction)

**Treatment Plan**

If a food allergen has been ingested, but no symptoms:  observe for symptoms  Epinephrine  Antihistamine  Albuterol

Observe for **Symptoms:**

<b>Mouth</b> Itching, tingling or swelling of lips, tongue, mouth	<b>Number order of Medication</b>
<b>Skin</b> Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol
<b>Stomach</b> Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol
<b>Throat*</b> Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol
<b>Lung*</b> Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol
<b>Heart*</b> Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol
<b>Other*</b> _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine <input type="checkbox"/> Albuterol

(\* Potentially life threatening; the severity of symptoms can quickly change)

**Medication Protocol**

Epinephrine: Inject into thigh (circle one): EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: Give \_\_\_\_\_ as directed on prescription label

Albuterol: Give \_\_\_\_\_ as directed on prescription label  may repeat  do not repeat

Other: Give \_\_\_\_\_





Medication/dose/route

- Emergency Response**
- Administer rescue medication as prescribed above
  - Stay with child
  - Contact parents/guardian

<p><b>IF THIS HAPPENS</b> </p> <p><b>GET EMERGENCY HELP NOW!</b></p> <p><b>CALL 911</b></p>	<ul style="list-style-type: none"> <li>• Hard time breathing with:             <ul style="list-style-type: none"> <li>○ Chest and neck pulled in with breathing</li> <li>○ Child is hunched over</li> <li>○ Child is struggling to breathe</li> </ul> </li> <li>• Trouble walking or talking</li> <li>• Stops playing and can't start activity again</li> <li>• Lips and fingernails are grey or blue</li> </ul>
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**How to give EpiPen® or EpiPen® Jr**

<p><b>1</b></p>  <p>Form fist around EpiPen® and pull off grey cap.</p>	<p><b>2</b></p>  <p>Place black end against outer mid-thigh. Support the child.</p>	<p><b>3</b></p>  <p>Push down <b>HARD</b> until a click is heard or felt and hold in place for 10 seconds.</p>	<p><b>4</b></p>  <p>Remove EpiPen™ and be careful not to touch the needle. Massage the injection site for 10 seconds.</p>
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Child's Name

## ALLERGY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

### Medications for Allergy

For children requiring rescue medication, the medication is required to be at program site at all times while child is in care. For youth who self-medicate and carry their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available.

### Field Trip Procedures

Rescue medications should accompany child during any off-site activities.

- The child should remain with staff or parent/guardian during the entire field trip.  Yes  No
- Staff members on trip must be trained regarding rescue medication use and this health care plan.  
This plan must accompany the child on the field trip.
- Other (specify) \_\_\_\_\_

### Self-Medication for School Age/Youth

**YES.** Youth can self-medicate. I have instructed \_\_\_\_\_ in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. Youth has been instructed not to share medications and should youth violate these restrictions the privilege of self medicating will be revoked and the youth's parents notified. Youth are required to notify staff when carrying medication.

OR

**NO.** It is my professional opinion that \_\_\_\_\_ SHOULD NOT carry or self administer his/her medication.

### Bus Transportation should be alerted to child's condition.

- This child carries rescue medications on the bus.  Yes  No
- Rescue medications can be found in:  Backpack  Waistpack  On Person  Other \_\_\_\_\_
- Child should sit at the front of the bus.  Yes  No
- Other (specify): \_\_\_\_\_

### Sports Events

Parents are responsible for having rescue medication on hand and administering it when necessary when the child is participating in any CYS sports activity. Volunteer coaches do not administer medications.

### Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the CYS nurse/APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child must have required medication with him/her at all times when in attendance at CYS programs.

### Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying medication.

### Follow Up

This Allergy Medical Action Plan will be updated/revised whenever medications or child's health status changes. If there are no changes, the Allergy Medical Action Plan will be updated at least every 12 months.

Printed Name of Parent/Guardian	Parent Signature	Date (YYYYMMDD)
Printed Name of Youth (if applicable)	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature  (This signature serves as the exception to medication policy)	Date (YYYYMMDD)

