MEDICATION POLICY & ACTION PLAN

For any participant with health care needs such as allergies, asthma, or other chronic conditions that require medication, a completed Medication Policy & Action Plan Packet must be attached to the application. **Only medications which are medically necessary and cannot be scheduled outside the hours of the recreation program will be administered during the program or kept on site.** Participants may not medicate themselves*. The Medication Policy & Action Plan Packet must be completed by the participant's parent/guardian and health care professional.

A Medication Policy & Action Plan Packet is required to administer medication and to have on site PRIOR to participant attending the program. The completed policy must accompany the medicine in its original container with instructions of the dosage. All medication (i.e. over-the-counter & prescription) and/or medical devices that may be used at the program of any kind will be kept in a central location. Program directors will assist or administer medication. It will be the responsibility of the participant to get their medicine from the program director. No participants should be in possession of over-the-counter or prescription medication. One packet per medication is required.

NOTICE: Please allow up to 2 weeks to process for approval if completed correctly. Certain medications that require medical support accommodations will require additional staff training & may take an extended amount of time and additional forms. A new Medication Policy & Action Plan Packet is required when registering for separate programs (i.e. camps, after school program). Packet information does not carry over from one school year to the next.

If participant must take medication of any kind during program hours, including over-the-counter drugs, the following will apply.

1. You can come to the program and give the medication to the participant at the appropriate time.
2. You may obtain a copy of the Medication Policy & Action Plan Packet upon request from the Burlington Recreation & Parks Main Office, program site, & online at www.BurlingtonNC.gov/youth. Take the form to the participant's doctor or health care professional and have them complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. **This form must be completed and signed by the authorized prescriber for both prescription and over-the-counter drugs.** The form must also be signed by the parent or guardian.
    a. Prescription medications must be brought to the program in a pharmacy labeled bottle that contains instructions on how and when the medication is to be given.
    b. Over-the-counter drugs must be received in the original container and will be administered according to the prescriber's written instructions.

***Some medications such as inhalers or emergency injections can be self-administered.**

(No medications, creams or ointments, can ever be left in participant's back packs or bags.)

Medical Support
Medical conditions may include but are not limited to: diabetes, epilepsy/seizure disorder, etc. Supports are individualized based upon the participant's specific condition and the program they attend. Additional forms are required from the parent/guardian and from the participant's treating healthcare provider before a specific support plan can be developed and additional participant-specific training can be provided to staff. The accommodation/support request should be received at least two weeks prior to the start date of the program so we can begin the process to provide support; however, this process can take an extended amount of time and advanced notice/registration is suggested. Non-medical staff performs procedures.

For more information or to request medical support, please contact (336) 222-5030.

City of Burlington – Recreation & Parks
PARENT/GUARDIAN'S PERMISSION FOR MEDICATION

I hereby give my permission for my child/participant _____ to receive medication during program hours. A practitioner authorized to prescribe medication has prescribed this medication. I hereby release the City of Burlington and their agents and employees from any and all liability that may result from my child/participant taking the prescribed medication.

_____

Signature of Parent/Guardian

_____

Telephone Number

_____

Date

(City of Burlington Use Only)

_____ _____

Signature of Youth Program Supervisor Date

_____ _____

Signature of Program Nurse Date

_____

Approval Date

City of Burlington – Recreation & Parks

MEDICATION ADMINISTRATION PERMISSION

Parent/guardian completes the Medication Administration Permission and must sign and date it.

The Health Care Professional must also sign off on medication.

Permission valid from date:	To date:

Only complete this box if the medication is for a participant who has a chronic medical condition or an allergy

□ This document is written permission to administer this medication for up to 6 months.

Specific chronic medical or allergic condition: _____

Participant has an □ Action Plan □ Individualized Health Care Plan **(please attach)**

Please check: □ Prescription □ Non-Prescription

Participant's full name:	Date of birth:
School/Camp:	Date:
Medication Name:	Expiration Date:

Medication color:	Medication type (tablet, liquid, ointment, etc.):

Date (s) to give medication:

When to give medication (choose one):

□ Give medication at these specific times (list times):

□ Give medication as-needed (write as-needed criteria below):
List the specific symptoms or circumstances needed to give the medication and how often it can be given.
For example: If Sally has a rash and is scratching it, apply this ointment to the rash. Wait at least 6 hours before reapplying.

Dosage (how much medication to give):

Route (how to give the medication):

Special instructions on how to give medication:

Relationship to meals:

Possible side effects or reactions:

□ Child has received at least 1 dose of medication at home without side effects

Prescribing health care professional name:	Phone:
Prescribing health care professional signature:	Date:
Pharmacy:	Phone:

I give authorization to give medication and to call the prescribing health care professional or pharmacy if needed

Parent/guardian name:	
Parent guardian signature:	Date:

Medication received, returned, or disposed of: (OFFICE USE ONLY)

Received from parent/guardian	**Date**	**Amount**	**Parent/Guardian Signature**	**Program Director Signature**
Returned to parent/guardian	**Date**	**Amount**	**Program Director Signature**	**Witness Signature**
Disposed of Medication	**Date**	**Amount**	**Program Director Signature**	**Witness Signature**

City of Burlington – Recreation & Parks

MEDICATION ADMINISTRATION RECORD

Person who gives the participant the medication completes this Medication Administration Record.

Two staff must be present & two staff must sign off that medication dose was accurate and all information is correct.

Attach page to the Medication Administration Permission.

If an error occurs and the participant requires medical attention, call 9-1-1 and/or Poison Control (800-222-1222) immediately.

Participant's Name:						
Medication Name:						
Date Given	Time Given	Dose Given	Route	Name of person giving medication	Signature of person giving medication	Reaction/side effect if observed
Date	Time	Error or misshape while giving medication		Parent/Guardian Notified	Program Director Signature	
				□ Yes □No		
				□ Yes □No		
				□ Yes □No		

Medical Action Plan - Asthma

10A NCAC 09 .0801 (centers) and .1721 (family child care homes)

Action plan's must be completed by the child's parent or health care professional, attached to the child's application, and updated annually. The completed action plan should be stored in the child's file and facility's Ready to Go File and a copy kept in the classroom.

Name of person completing form:	Today's date:
Child's full name:	Date of birth:
Parent/guardian:	Phone:
Primary Health Care Professional name:	Phone:
Primary Health Care Professional signature:	

Asthma Triggers (Avoid exposure to triggers)				**Severity of asthma**
□ Carpet	□ Mold	□ Cockroaches	□ Changes in weather	□ Mild intermittent
□ Animals	□ Pollen	□ Chemical sprays	□ Illness	□ Mild persistent
□ Tobacco smoke	□ Dust (mites)	□ Strong odors	□ Other:_____	□ Moderate persistent
				□ Severe persistent
List Allergies:				

Consult with a Child Care Health Consultant about this plan.

GREEN - GO
Child is breathing well.

No cough or wheeze.

Sleeps well at night.

Plays actively.

No early warning signs.

Use these long-term CONTROL medicines **every day** to keep child in the green zone.

Medicine:	How much to give:	When to give:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication before active play or exercise: ☐ None needed

☐ Medication _____ Give _____ minutes before active play or exercise.

YELLOW – CAUTION
Child has some problems breathing.

Keep using long-term CONTROL green zone medicines every day. **Add** quick-relief medicines to keep asthma from becoming worse. Parent/legal guardian contacts the Health Care Professional when quick-relief medicine is used more than twice in a week.

Coughing
- Wheezing
- May squat or hunch over
- Chest tight

- Waking often
- Poor appetite
- Decreased play or activity

Other early symptoms (child specific):

_____
_____
_____

At Home

Medicine:	How much to give:	When to give:
Albuterol _____ OR _____	___ 2 puffs by inhaler (with spacer) ___ by nebulizer (with mask)	Give first dose as soon as possible. Repeat every ____ minutes for up to a total of ____ doses if needed.
If symptoms **return** to **Green Zone**:		If symptoms do not return to **Green Zone** within 1-2 hours**:**
• Take quick-relief medicine every 4 hours for ___ days. • Change long-term control medicines to _____ for ___ days. • Contact Health Care Professional for follow-up care if symptoms return.		Take quick-relief medication again. Contact Health Care Professional.

At Child Care

Medicine:	How much to give:	When to give:
Albuterol _____ OR _____	___ 2 puffs by inhaler (with spacer) ___ by nebulizer (with mask)	Give first dose as soon as possible. Call parent/guardian if symptoms do not return to green zone within 15 minutes. Repeat every _____ minutes for up to a total of _____ doses if needed.
If symptoms **return** to **Green Zone:**		If symptoms **do not return** to **Green Zone** within 1 hour**:**
Continue quick-relief medicine every 4 hours for remainder of time in care.		Have parent/guardian pick child up and care for the child.

See page 2 for RED – DANGER: Child has severe problems with breathing.

Medical Action Plan - Asthma

10A NCAC 09 .0801 (centers) and .1721 (family child care homes)

<table>
<tr><td colspan="2">RED – DANGER
Child has severe problems with breathing.</td><td colspan="3">Get help!
Give quick-relief medicines until help arrives.</td></tr>
<tr><td rowspan="4">Severe Symptoms
Getting worse instead of better.
Coughing constantly.
Cannot talk well.
Cannot play or walk.
Breathing is hard and fast, gasping.
Nostrils open wide when child breathes.
Chest muscles tight. Space between the ribs and over the chest bone suck in with each breath.
Fingernails or lips blue.</td><td rowspan="2">CHILD HAS SEVERE SYMPTOMS!
  </td><td colspan="3">At Home</td></tr>
<tr><td>Medicine:</td><td>How much to give:</td><td>When to give:</td></tr>
<tr><td rowspan="2">CALL 9-1-1 if symptoms last more than a few minutes.
  </td><td>Albuterol _____

OR _____</td><td>___ 2 puffs by inhaler (with spacer)
___ by nebulizer (with mask)</td><td>• Give a dose immediately and call Health Care Professional.
• Repeat every ____ minutes until medical help is obtained.
• Do not leave child alone.</td></tr>
<tr><td colspan="3">At Child Care</td></tr>
<tr><td></td><td>Medicine:</td><td>How much to give:</td><td>When to give:</td></tr>
<tr><td></td><td>Albuterol _____

OR _____</td><td>___ 2 puffs by inhaler (with spacer)
___ by nebulizer (with mask)</td><td>• Give a dose immediately.
• Call parent/guardian if not previously called.
• Call Health Care Professional if unable to reach parent/guardian.
• Repeat dose every _____ minutes until medical help is available.
• Do not leave child alone.</td></tr>
</table>

Plan reviewed by:

Child Care Director/Operator name:	Date:
Signature:	
Child Care Health Consultant name:	Date:
Signature:	

Child care staff trained to care for child:

#1:	#2:	#3:
Who will move and/or care for other children?		
Who will notify the child's parents?		
Who will call and assist EMS (911) when needed?		
Who will go to the hospital when needed and stay with child until parent/legal guardian assumes responsibility?		

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

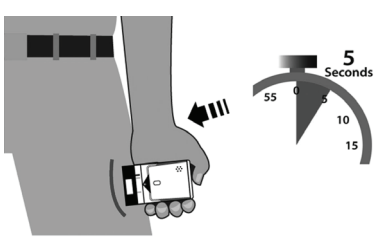
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

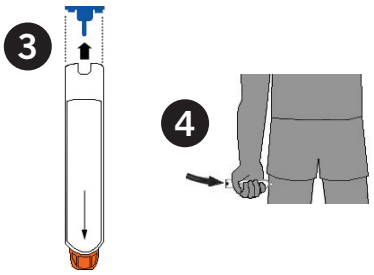
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



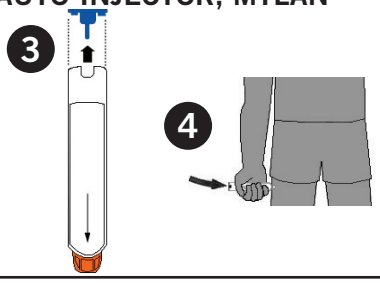
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



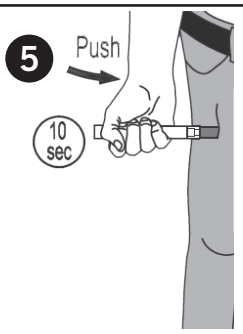
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

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