

TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
2020/2021 MEDICAL FORM INSTRUCTIONS FOR EPI-PEN

*** PLEASE NOTE: We are unable to dispense Benadryl.**

According to New York State Office of Children and Family Services, these are the only forms that will be accepted and must be completed entirely. Unfortunately, School District forms cannot be accepted. All medical forms (a total of 6 pages) are due in our office no later than August 1st.

*These signatures are valid for one-year from date signed. *

Please follow instructions below:

1. Medical Report Form (1 Page): Must be filled out completely, signed, stamped and dated by Physician. Physical is not required if child has had one within the last 2 years.
2. Allergy/Anaphylaxis/Epi-Pen Emergency Plan (1 Page): Bottom portion must be filled out and signed by parent. Any information that does not apply, parent must draw a line through and initial. These signatures are valid for one-year from date signed.
3. Medication Consent Form (2 Pages): Physician must fill out in its entirety and sign bottom of page 1, parent must review for accuracy and sign top of page 2. Section #31-35 does not have to be completed unless applicable. *The information written on these pages **MUST** match the information printed on prescription label. (see below).*
4. Individual Health Care Plan- Epi-Pen: (2 Pages)
 - Page 1: Must be filled out by parent in its entirety. ***Parent must outline a detailed description of allergies including symptoms, when the epi-pen should be administered, instructions on use, and what steps should be followed after the epi-pen has been injected.**
 - Page 2: Parent must sign and date bottom portion of form.

******IMPORTANT******

EPI-PEN WILL NOT BE ACCEPTED IF:

- THE EPI-PEN IS EXPIRED
- THE EPI-PEN IS NOT IN THE ORIGINAL CONTAINER WITH THE CHILD'S NAME ON THE PRESCRIPTION LABEL
- THE (MEDICATION NAME/DOSAGE IF APPLICABLE) DOES NOT MATCH.
EXAMPLE: THE INFORMATION ON THE EPI-PEN AND PAPERWORK MUST READ EXACTLY THE SAME!! THERE WILL BE NO EXCEPTIONS.

All forms must be filled out according to instructions or they will not be accepted as per OCFS Regulations.

**TOWN OF SMITHTOWN SCHOOL AGE CHILD CARE
ALLERGY /ANAPHYLAXIS /EPI-PEN EMERGENCY PLAN**

Child's Name: _____ Name of School: _____

Child's Date of Birth: _____ Address: _____

Child is allergic to: _____

The School Age Child Care Program may serve snacks manufactured in a facility that produces nuts. The School Age Child Care Program cannot guarantee that nuts will not be brought into the program. Refer to Parent Handbook regarding snack policy.

Prescribed Medication: Epi-Pen Auto Injector, Epi-Pen Jr, Epinephrine

Please note: The School Age Child Care Program is unable to dispense Benadryl.

It is the parent's responsibility to provide the School Age Child Care Staff with epi-pens in the original containers with the child's name on the label. The parent will ensure that the epi-pen is up to date and not expired. The parent will instruct the School Age Child Care Staff on the use of the epi-pen.

**When to give EPINEPHRINE (Epi-Pen): AT ONSET OF SEVERE ALLERGIC REACTION/
ANAPHLAXIS.**

**SEVERE ALLERGIC REACTION/ ANAPHLAXIS : ITCHING, SWELLING, SNEEZING,
COUGHING, HIVES, RASH, NAUSEA, ABDOMINAL CRAMPING, VOMITING, DIARRHEA,
THROAT CLOSING, DIFFICULTY BREATHING, CHOKING, DIZZINESS, LOSS OF
CONSCIOUSNESS.**

**SIDE EFFECTS OF EPI-PEN: SHAKINESS, INCREASED HEART RATE, POSSIBLE NAUSEA/
VOMITING.**

HOW TO GIVE EPINEPHRINE (EPI-PEN)

1. Remove inner epi-pen from outer casing.
2. Remove cap.
3. Jab into outer aspect of thigh and hold for 10 seconds.

Note: Auto injector- no plunger to push

**NOTE: PATIENT MUST BE TRANSPORTED TO EMERGENCY ROOM IMMEDIATELY AFTER
ADMINISTRATION OF EPINEPHRINE!!**

**2ND DOSE OF EPINEPHRINE (EPI-PEN) MAY BE GIVEN 5-15 MINUTES AFTER 1ST DOSE IF
SEVERE SYMPTOMS WORSEN BEFORE AMBULANCE ARRIVES.**

Parent Request for SACC Staff to Administer Epi-Pen

I, hereby, request that my child, _____, be given the medication above as prescribed by the physician. I, the parent, authorize the Town of Smithtown School Age Child Care Staff to administer an epi-pen and agree that we will not hold liable any member of the School Age Child Care Staff or individual of official capacity who is directed by me (the parent) in administering the medication. I understand that my child is not able to attend the program when expired medication is on site.

Parent/Guardian Signature

Date

*This signature is valid for one-year from date signed

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? <i>(For example, did the licensed authorized prescriber write 12pm?)</i> <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the child day care program is to administer the medication <i>(i.e.: 12 pm)</i> : _____	
20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to <i>(child's name)</i> : _____	
21. Parent's Name <i>(please print)</i> : _____	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: _____
27. I have verified that (#1 - #23) and if applicable, (#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.		
28. Staff's Name <i>(please print)</i> : _____	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

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place. DATE: _____ By completing this section, the day care program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
35. Licensed Authorized Prescriber's Signature: X

