

Individual Health Care Plan requiring **EPI Pen**

Child's Photo

This form to be used for any child who has been prescribed an EPI Pen. It **must** be signed by a Health Care Professional. Plan must be renewed annually or when child's condition changes

Check all that apply...

Plan was created by:

Parent / Guardian
 Doctor or Licensed Practitioner
 Other _____

Plan is maintained by:

Co -Director _____
 Office Administrator _____
 Other _____

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Child's name _____ D.O.B. _____ Date _____

Name of chronic health care condition:

Description of chronic health care condition requiring **EPI PEN**:

Symptoms: please check all that apply
 itching, tingling nausea wheezing
 swelling tightening of throat shortness of breath
 hives coughing

Medical **treatment** necessary while at the program:
Epinephrine: inject intramuscularly (circle one) EPI PEN 0.3mg EPI PEN 0.15mg
Repeat in _____ minutes if symptoms continue to progress

Potential **side effects** of treatment: circle those that apply
increased heart rate, dizziness, nausea, vomiting, weakness, anxiety

Potential **consequences** if treatment is not administered:
Anaphylaxis

Is Benedryl required? (circle one) Yes No
Dosage to be administered: Liquid _____ Tablets _____
We can only administer exactly what is written.

Potential **side effects** of treatment: circle those that apply
drowsiness, fatigue, sleepiness, dizziness, upset stomach

I authorize the parent or program's health care consultant to train ASC's staff in my child's health care needs and treatment.

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental / Guardian consent _____ Date: _____

Name of staff who received training addressing the medical condition:

Name of person (child's health Care Practitioner, child's parent, program's health care consultant) who trained the staff:
Child's Parent

For Older Children ONLY (9+ years of age) who have permission to carry their own medication:
With written parental consent **and** authorization of a licensed health care professional, this IHCP permits older school age children to carry their own inhaler and/or EpiPen and use them as needed without the direct supervision of an ASC staff member. The inhaler / EpiPen will be stored in a zippered section of the child's backpack.
The staff members are aware of the contents and requirements of the child's IHCP specifying how the inhaler or EpiPen will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed. Back up medication received? YES NO
The child named above, age _____ has permission to carry and self administer his INHALER EPI-PEN
Licensed Health Care Practitioner signature: _____ Date: _____
Parent/Guardian signature _____ Date _____

ASC signature _____ Date _____

q=every, q4° = every 4 hours, BID = 2X a day, QID = 4 X a day, NOS=not otherwise specified, PO = by mouth, HS=night time,