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_____

THIS MUST ALL BE FILLED OUT

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:X_____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_____ 8/11/2021

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,