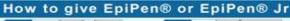
CYS SERVICES SNAP ALLERGY MEDICAL ACTION PLAN (to be completed by Health Care Provider)				
Child's Name Date of Birth	Date			
Sponsor Name				
Health Care Provider	Health Care Provider Phone			
Allergies (please list)				
J ,	<u> </u>			
	Asthmatic □ Yes* □ No (*Higher risk for severe reaction)			
Treatment Plan				
If a food allergen has been ingested, but no symp	toms: _ observe for symptoms _ Epinephrine _ Antihistamine _ Albuterol			
Observe for Symptoms: Mouth Skin Stomach Throat* Lung* Heart* Other* Mouth Hives, itchy rash, swelling of the face or extremities Nausea, abdominal cramps, vomiting, diarrhea Tightening of throat, hoarseness, hacking cough Shortness of breath, repetitive coughing, wheezing Weak or thready pulse, low blood pressure, fainting (* Potentially life threatening; the severity of symptoms can qui	_ Epinephrine _ Antihistamine _ Albuterol _ Epinephrine _ Antihistamine _ Albuterol g _ Epinephrine _ Antihistamine _ Albuterol g, pale, blueness _ Epinephrine _ Antihistamine _ Albuterol _ Epinephrine _ Antihistamine _ Albuterol _ Epinephrine _ Antihistamine _ Albuterol			
Medication Protocol				
Epinephrine: Inject into thigh (circle one): EpiPen®				
Medication/dose/route				
 Administer rescue medication as prescribed above Stay with child Contact parents/guardian 				
IF THIS HAPPENS GET EMERGENCY HELP NOW! CALL 911 - Hard time breathing with: Chest and neck pulled in with breathing Child is hunched over Child is struggling to breathe Trouble walking or talking Stops playing and can't start activity again Lips and fingernails are gray or blue				





Form fist around EpiPen® and pull off grey cap.



Place black end against outer mid-thigh. Support the child.



Push down HARD until a click is heard or felt and hold in place for 10 seconds.





Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

Child's Name		
ALLERGY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS (to be completed by Health Care Provider) Medications for Allergy		
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		
□ <u>YES</u> . Youth can self-medicate. I have instructedin 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		
□ <u>NO</u> . It is my professional opinion thatSHOULD 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.		
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)
Timed Name of Touri (ii applicable)	Touth dignature	Date (TTTTWWDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
·		,
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)
	(This signature serves as the exception to medication policy)	