Anne Arundel County Department of Recreation and Parks

ACKNOWLEDGMENT OF ALLERGIES/MEDICAL CONDITIONS
(only sign if applicable)

CHILD'S NAME: _____

PROGRAM LOCATION AND NAME:_____

I acknowledge that allergies and/or medical conditions are listed on my child's *Registration or Participant Emergency Information Form*, that I presented to Anne Arundel County and the Department of Recreation and Parks that my child has no medications that he or she is taking or needs to have available while attending the Recreation and Park program, and that I have provided Recreation and Parks with no medications or equipment to treat those conditions.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (Please print name clearly on this line)

Revised 07/2011

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Anne Arundel County Recreation & Parks
1 Harry S Truman Parkway, Annapolis, MD 21401
410-222-7300 (office)
410-222-4120 (fax)
www.aacounty.org/recparks

I. CAMP STAFF

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An adult must bring the medication to the camp and give the medication to an adult staff member.**
- **A photo of the camper must be attached to this form.**

CAMP NAME:

II. PRESCRIBER'S AUTHORIZATION

CHILD'S NAME		DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE	ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
MEDICATION SHALL BE ADMINISTERED *(NOT TO EXCEED 1 YEAR)*	FROM	TO

PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	DATE

III. PARENT/GUARDIAN AUTHORIZATION

I request authorized youth camp operator/staff to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

IV. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE

Anne Arundel County Recreation & Parks
Asthma Medication Administration Authorization Form
ASTHMA ACTION PLAN for ___/___/__ to ___/___/___ (not to exceed 12 months)

Maryland State Department of Education — Preparing World-Class Students

Triggers (list)

_____
_____
_____
_____
_____
_____
_____

Student's

Name:_____ **DOB:**_____ **PEAK FLOW PERSONAL BEST:**_____

ASTHMA SEVERITY: ☐ **Exercise Induced** ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent**

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Long Term Control Medication — use daily at home unless otherwise indicated

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency
(Rescue Medication)			

☐ **Prior to exercise/sports/ physical education**

If using more than twice per week for exercise, notify the health care provider and parent/guardian.

YELLOW ZONE: Quick Relief Medications — to be <u>added</u> to Green zone medications for symptoms

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____

☐ Peak flow between _____ and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE: Emergency Medications— Take these medications and <u>call 911</u>

☐ Medication is not helping within 15-20 mins
☐ Breathing is hard and fast
☐ Nasal flaring or skin retracts between ribs
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other:_____
☐ Peak flow less than _____ (50% personal best)

Medication	Dose	Route	Frequency

Contact the parent/guardian after calling 911.

Health Care Provider and Parent Authorization

I authorize the child care provider to administer the above medications as indicated. Student may self-carry medications: **[School-age children)** ❑**Yes** ❑**No**

Prescriber signature: _____ **Date:** _____ **Parent / Guardian Signature:** _____ **Date:** _____

By signing below, I certify that the child is authorized to self-carry/self-administer medication and authorize the child to self-carry/self-administer the medications indicated during any child care and before/after school programs.

Prescriber signature: _____ **Date:** _____ **Parent / Guardian Signature:** _____ **Date:** _____

Reviewed by Child Care Provider: Name: _____ **Signature:** _____ **Date:** _____

Anne Arundel County Recreation & Parks

Allergy Action Plan

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

TREATMENT

CHILD'S NAME: _____ **Date of Birth**: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: tightening of throat, hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

_____ _____

Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed.

Doctor's Name: _____ Phone Number: _____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

_____ _____

Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

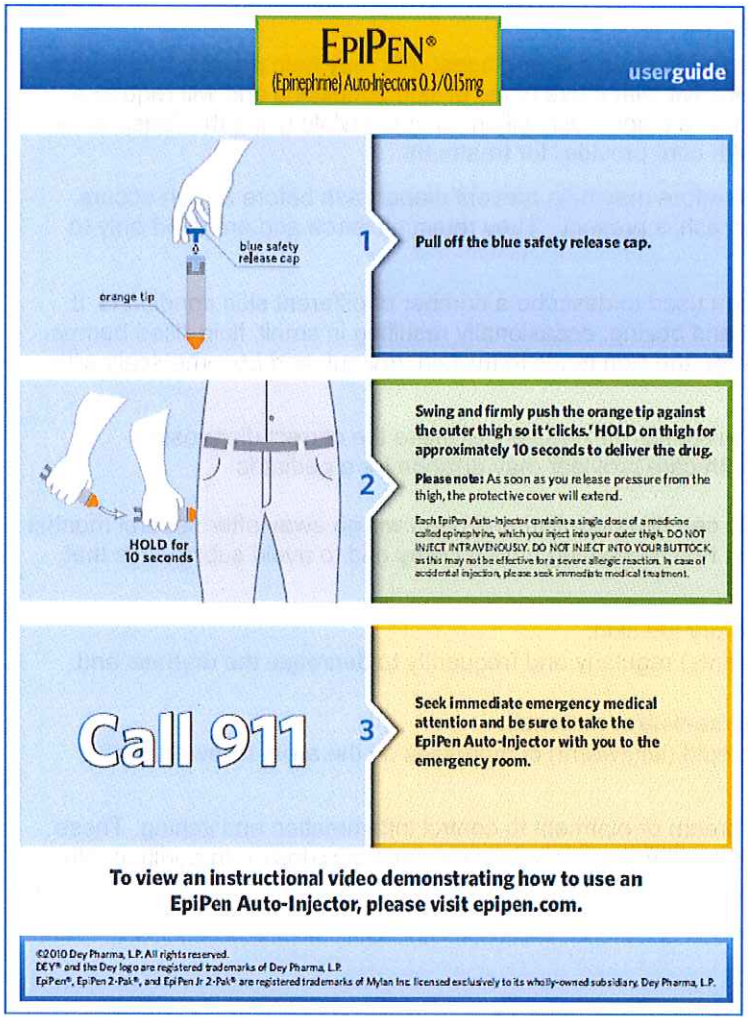
CHILD'S NAME: _____ **Date of Birth**: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

Anne Arundel
RECREATION AND PARKS
1 Harry S. Truman Parkway
Annapolis, MD 21401
(410) 222-7313 or (301) 261-8036

PERMISSION TO APPLY OVER THE COUNTER CREAMS, OINTMENTS AND SUNSCREEN

Name Of Child: _____ Date of Birth: _____

Parent or Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

This form is to be used for over the counter topicals only. Any prescription creams, lotions, ointments, etc. require the AACo Recreation & Parks Medication Form. Children are expected to apply these topicals. This form is to be used for non-medicated sunscreen, lip balm, vaseline, lotions, creams, ointments, etc. that are to be applied to external areas only. Siblings may not share. Any cream, lotion, ointment, etc. must be provided by the parent and labeled in permanent marker with the child's name. It should also have been applied at home prior to attending our programs to ensure no adverse effect to the child (i.e. rash, irritation or other reaction). Please list all topicals separately.

1. _____
Type of Topical Brand Name Area of Body to be Applied

2. _____
Type of Topical Brand Name Area of Body to be Applied

3. _____
Type of Topical Brand Name Area of Body to be Applied

My child has previously used the above product(s) with no adverse reaction(s).

_____
Parent or Guardian Signature Date

FOR SUNSCREEN USE ONLY:

Children will be expected to apply their own sunscreen. Please practice this at home. Staff may assist with your signed permission only.

_____
Parent or Guardian Signature Date