Medication Authorization Form
For Prescription and Non-Prescription Medications

(8VAC20-780-510)

Section A must be completed by the parent/guardian for **ALL** medication authorizations which shall expire or renewed after 10 work days.
Section A and Section B must be completed for any **long-term prescription and over-the-counter medication which** may be allowed with written authorization from the child's physician and parent.

Sec on A: To be completed by parent/guardian

Medication authorization for: _____
(child's name)

_____has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
(Start date) **(End date)**

Parent or Guardian's Signature: _____ **Date**: _____

Section B: to be completed by child's physician:

I, _____ certify that it is medically necessary for the medication(s) listed
(name of physician)

below to be administered to:_____ for a duration that exceeds 10 work days.
(child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
(Start date) **(End date)**

Physician's Signature: _____

Physicians Phone: _____ Date: _____

Food Allergy Action Plan

ALLERGY TO: _____

Students Name: _____ DOB _____

Teacher: _____

ASTHMATIC: YES * ☐ NO ☐ * **HIGH RISK FOR REACTION**

Place Childs Photo Here

SIGNS OF ALLERGIC REACTIONS

Please check below the medications your child must take during an allergic reaction

SYMPTOMS	**Give Checked Medication**	
• **If exposed to an allergen, but no symptoms** give…	□ EpiPen	□Benadryl
• **Mouth:** itching and swelling of the lips, tongue, or mouth give…	□ EpiPen	□Benadryl
• **Throat*:** itching and/or a sense of tightness in the throat, hoarseness, and hacking cough	□ EpiPen	□Benadryl
• Skin: hives, itchy rash and/or swelling about the face or extremities	□ EpiPen	□Benadryl
• Gut: nausea, abdominal cramps, vomiting and/or diarrhea	□ EpiPen	□Benadryl
• **Lung***: shortness of breath, repetitive coughing, and/or wheezing	□ EpiPen	□Benadryl
• **Heart*:**"thready" pulse, "passing out"	□ EpiPen	□Benadryl

*** ALL ABOVE SYMPTOMS PERTAINING TO THROAT, LUNG AND/OR HEART CAN POTENTIALLY PROGRESS TO LIFE THREATNING SITUATION**

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _____ give _____ ***(Medication, Dose and Route)***

2. Then Call: Mother _____ Father _____ or emergency contacts.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptoms are_____ give _____ immediately!
(Medication, Dose and Route)

2. Call 911 (ask for advanced life support) if you have given an Epi-Pen injection. *Be ready to give an additional dose of Epinephrine in 15 minutes if ambulance has not arrived.*

3. Then Call: Mother _____ Father _____or emergency contacts.

Emergency Contacts

First: _____	Second:_____	Third:_____
Relationship:_____	Relationship:_____	Relationship:_____
Phone: _____	Phone: _____	Phone:_____

Parents Signature: _____ Date: _____