JBSA Child and Youth Programs

ALLERGY MEDICAL ACTION PLAN

AUTHORITY: DoDD 1342.17 Family Policy, , AFI 34-248 Child Development Center; C41 Air Force Child Development Inspection criteria
PRINCIPAL PURPOSE: Information will be used to assist Air Force activities in their responsibilities with overall execution of Inclusion Action Team functions.
ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of compilation of system of records for Child and Youth Program Registration.
DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Child and Youth Programs.

Child/Youth's Name	**Date of Birth**	**Date**	**Sponsor Name**
Sponsor/Guardian Phone Number	**Health Care Provider**		**Health Care Provider Phone Number**

MEDICATION /TREATMENT PLAN

Allergies:	**Symptoms:**	**Medication (Per physician order):** **Can Self-Carry:** ☐ **Yes** ☐ **No** **Can Self-Medicate:** ☐ **Yes** ☐ **No**
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NOTIFICATION/CONSENT

Parent's signature gives permission for CYP Services personnel who have been trained in medication administration by qualified medical personnel to administer prescribed medicine and to contact emergency medical services if necessary. Must be approved by a licensed health care provider to self-medicate. My child/youth has been instructed on the proper way to use his/her medication. S/he understand not to share medications. A licensed health care provider include: a doctor of medicine (MD), osteopathic physician (DO), certified registered nurse practitioner (NP), or certified physician's assistant (PA). If these guidelines are violated, CYP Services privileges may be restricted or revoked. Rescue medication must be on hand during all CYP Services Programs.

CYP Services staff/providers are to notify parent/guardian immediately if medication is given.

I agree with the plan outlined above.

Name of Parent/Guardian	**Parent/Guardian Signature**	**Date (YYYYMMDD)**
Name of Youth (*If applicable*)	**Youth signature (*If applicable*)**	**Date (YYYYMMDD)**
Stamp pf Health Care Provider	**Health Care Provider Signature**	**Date (YYYYMMDD)**
Name of Nurse Liaison or APHN	**Nurse Liaison/APHN Signature**	**Date (YYYYMMDD)**

FOLLOW-UP

This Respiratory Medical Action Plan must be update/ revised whenever medications or child/youth's health status changes. If there are no changes, the Medical Action Plan must be updated every 12 months.

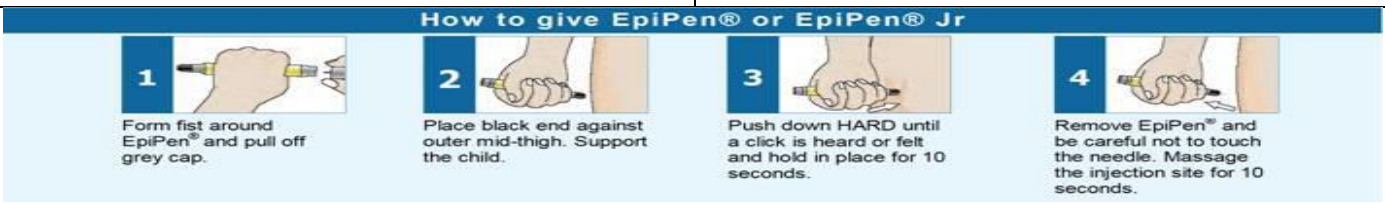
Child/Youth's Name	Date of Birth: (YYYYMMDD)

ALLERGY MEDICAL ACTION PLAN-ADDITIONAL CONSIDERATIONS

EMERGENCY RESPONSE

- Administer rescue medication as prescribed
- Stay with child/youth
- Contact parent/guardian

IF THIS HAPPENS → GET EMERGENCY HELP NOW! CALL 911	• Hard time breathing with: - Chest and neck pulled in with breathing - Child/Youth is hunched over - Child/Youth is struggling to breathe • Trouble walking or taking • Stops playing and can't start activity again • Lips and fingernails are gray or blue



Any SEVERE SYMPTOMS after suspected or known ingestion One or more of the following: LUNG: Short of breath, wheezing, repetitive coughing HEART: Pale, blue, faint, weak pulse, dizzy, confused THROAT: Tightness, hoarseness, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Numerous hives over body Or combination of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (i.e. eyes, lips) STOMACH: Vomiting, cramping	→	1. INJECT EPINEPHRINE IMMEDIATELY 2. Call 911 3. Begin monitoring 4. Give additional medications: - Antihistamine - Inhaler (bronchodilator) if asthma Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE
MILD SYMPTOMS AND/OR TRIGGERS MOUTH: Itchy mouth/Tingling SKIN: A few hives around mouth STOMACH: Mild nausea/discomfort	→	1. GIVE ANTIHISTAMINE AND/OR BRONCHODILATORS 2. Notify Parent to come pick up child 3. Stay with child, monitor continuously for severe symptoms. USE EPINEPHRINE if symptoms become SEVERE (see above)

MEDICATIONS

For a child/youth requiring rescue medication, the medication is required to be at program site at all times while child/youth is in care. Child/youth without prescribed rescue medication are not permitted to participate in program. For youth who self-carry and administer their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available

FIELD TRIP PROCEDURES

Rescue medication should accompany child/youth during any off-site activities.

Staff members on trip must be trained on rescue medication use and this health care plan.

This plan must accompany the child/youth on the field trip.