

**TOWN OF FAIRFIELD PARKS & RECREATION SUMMER PLAYGROUND PROGRAMS
EPI-PEN AUTHORIZATION FOR PARTICIPANT WITH A KNOWN FOOD OR BEE STING ALLERGY**

Name of Participant _____ Date of Birth _____

Specific Food, Insect or Another Allergen _____

To order one of the allergy medication protocols below for this student, please **check off and complete** the appropriate section and sign.

- For a child with known food or bee sting allergy and a history of a life-threatening allergic reaction* to the food/sting: If child thinks he ate or knowingly ate the food or was stung: **Administer epinephrine immediately.**

Circle one: Epipen (epinephrine 0.3mg) IM or SC Epipen, Jr. (epinephrine 0.15mg) IM or SC

___ Repeat x 1 in 15-20 minutes as needed for symptoms of allergic reaction

Prescriber: Please prescribe two Epipens/Epipen, Jr.'s for child to have in school if repeat dose is ordered.

_____ Child participant may self-administer. Medication will be administered by a trained staff member or by the child if he/she has been approved to self-administer the medication. **Self-administration of medication means** that the child will carry and administer his/her medication without assistance. Self-administration must be authorized by the prescriber and parent / guardian and approved by the Site Director / staff. The staff will periodically supervise the student as needed.

Side effects/plan for management: _____

*Life threatening allergic reaction – a reaction involving the mouth, throat, respiratory, cardiovascular, or gastrointestinal system or involving the skin and a feeling of apprehension, impending doom, or weakness.

Duration of Order(s): from _____ to _____
(date) (date)

(date) _____ M.D./D.O./D.D.S./A.P.R.N./P.A.

Address and Telephone _____

- For a child with a history of non-life threatening** allergic reaction to a food or bee sting: If child thinks he ate the food, or knowingly ate the food or was stung:

Observe child for at least two hours for any signs of a reaction.

Administer epinephrine if any of these symptoms occur:

Respiratory difficulty, cough, repetitive sneezing, dizziness, faintness, signs of shock, tightness, itching of throat,
Difficulty swallowing, nausea, vomiting, cramps, diarrhea, swelling of lips, mouth, tongue, throat, hives or rash
Combined with apprehension, weakness, or sense of impending doom.

Circle one: Epipen (epinephrine 0.3mg) IM or SC Epipen, Jr. (epinephrine 0.15mg) IM or SC

___ Repeat x 1 in 15-20 minutes as needed for symptoms of allergic reaction.

Prescriber: Please prescribe two Epipens/Epipen, Jr.'s for child to have in school if repeat dose is ordered.

_____ Child may self-administer. Medication will be administered by a trained staff member or by the child if he/she has been approved to self-administer the medication. **Self-administration means** that the child will carry and administer his/her medication without assistance. Self-administration must be authorized by the prescriber and parent-guardian and approved by the Site Director / staff. The staff will periodically supervise the student as needed.

**Non-life threatening allergic reaction – a reaction involving only the skin or only a feeling of apprehension, of impending doom, or weakness.

Duration of Order(s): from _____ to _____
(date) (date)

(date) _____ M.D./D.O./D.D.S./A.P.R.N./P.A.

Address and Telephone _____

PARENT/GUARDIAN PLEASE COMPLETE THE OPPOSITE SIDE OF THIS FORM

TOWN OF FAIRFIELD PARKS & RECREATION PLAYGROUND PROGRAMS

Summer Fun, Playgrounds, Action Squad and Special Recreation

AUTHORIZATION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF EPI PEN

Connecticut State Law requires the written medication order of a physician, dentist, or an Advanced Practice Registered Nurse or Physician's Assistant licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered on school grounds. All Epi Pens shall be stored in their original container. All Epi Pens, except those approved for transporting by students for self-medication, shall be delivered to the Recreation Program by the parent or guardian or other responsible adult. No more than a 15-day supply of medication may be kept at the site. Epi Pens will be administered by a trained staff member or by the student if he/she has been approved to self-administer the medication.

Name of Participant _____ Date of Birth _____

Site _____ Session _____ Grade Entering _____

Epi Pen Medication _____

I hereby give my permission for my child to receive the above medication in the Fairfield Parks and Recreation program as ordered by his/her physician or other authorized prescriber.

Self-administration of Epi Pen means that the child will carry and administer his/her Epi Pen without assistance. Self-administration must be authorized by the prescriber and parent-guardian and approved by the Site Director / staff. The staff will periodically supervise the child as needed.

Child may self-administer the Epi Pen: (circle one): Yes No

I give my permission for communication between the Fairfield Recreation staff and prescriber of this medication as needed for implementation of that medication order on school grounds.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of the program, whichever comes first.

| | | |
|------|---------------------------------|-----------|
| Date | Signature of Parent or Guardian | Telephone |
|------|---------------------------------|-----------|

Print Name of Parent or Guardian

Rev. 7/05
SHM. Vol. 11, Sec. 3, Medications

PHYSICIANS, PLEASE COMPLETE THE OPPOSITE SIDE OF THIS FORM