EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)

CYS SERVICES ALLERGY MEDICAL ACTION PLAN

PROOF

For use of this form, see AR 608-75; the proponent agency is ACSIM.

(To be completed by a licensed Healthcare Provider)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDI 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; DoDI 6060.02, Child Development Programs; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in the overall execution of the Army's Exceptional Family Member Program and Child, Youth and School Services Programs.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to utilize Army Child, Youth and School Services.

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 *(as directed on prescription label)*:
		Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No
Allergies:	Symptoms:	Medication *(as directed on prescription label)*: May administer second dose of Epinephrine after (15 or less) ____ minutes if symptoms worsen or do not resolve.
		Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No
Allergies:	Symptoms:	Medication *(as directed on prescription label)*:
		Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No

NOTIFICATION/CONSENT

Parent's signature gives permission for CYS Services personnel who have been trained in medication administration by the APHN/CYS Services Nurse to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child/youth must have required medication with him/her at all times when in attendance at CYS Services programs and 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 understands not to share medications. Licensed health care providers authorized to provide approval are doctors of medicine (MD), osteopathic physicians (DO), certified registered nurse practitioners (NP), or certified physician's assistants (PA). If these guidelines are violated, CYS Services privileges may be restricted or revoked. Rescue medication must be on hand during all CYS Services Programs. **CYS 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 of Health Care Provider	Health Care Provider Signature	Date *(YYYYMMDD)*

Name of Army Public Health Nurse	Army Public Nurse Signature	Date *(YYYYMMDD)*

FOLLOW-UP

This Medical Action Plan must be updated/revised whenever medications and/or the health status of the child/youth changes. The Medical Action Plan must be updated every 12 months.

Child/Youth's Name

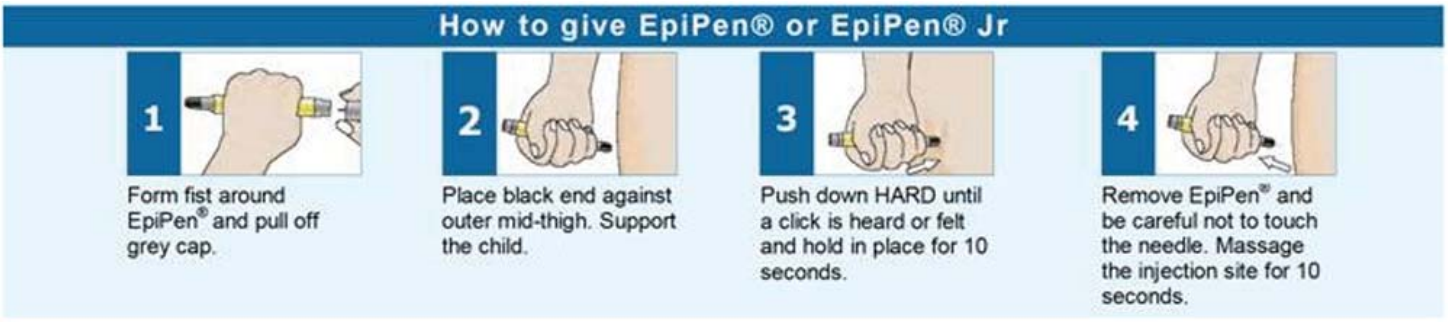
ALLERGY MEDICAL ACTION PLAN - ADDITIONAL CONSIDERATIONS

EMERGENCY RESPONSE

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

IF THIS HAPPENS → GET EMERGENCY HELP NOW! CALL 911/Emergency Medical Services

- Trouble walking or talking
- Stops playing and can't start activity again
- Lips and fingernails are gray or blue



For **SEVERE SYMPTOMS** **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 or Emergency Medical Services 3. Begin monitoring 4. Give additional medications as ordered by a licensed medical provider: - 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/face, mild itch 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 medications must accompany child/youth during all Child, Youth and School Services Programs

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.