Loudoun County Parks, Recreation and Community Services

Short-Term Medication Authorization Form: Up to 10 business days

***this form may only be used twice in one program year per medication**

Child's Name_____ **PRCS Program/Location**_____

Staff Name (Receiving Medication)_____ **Date of Receipt**_____

Instructions for Parents (Initial on each line that you acknowledge the step by step instructions):

____A separate form must be completed for each medication given.

____This form can only be renewed once per program after the initial 10 business day period has expired. If renewed, authorization dates and parent signature must be updated.

____A long-term medication authorization form is needed immediately for any medications that shall be kept on-site longer than 10 business days, including emergency medications such as epinephrine and inhalers. The long-term medication authorization requiring physician's authorization must be complete and accompany any medications beyond the expiration indicated on this form.

____The PRCS Food Allergy Action Plan (attached) MUST be completed in addition to this form if the child has a diagnosed food allergy.

____The medication must be in original packaging complete with direction label or prescription label.

____The medication and packaging must be labeled with the child's name (ie-label the bottle and the box).

____This authorization must list the child's name, the name of the medication on the box exactly as it reads, dosage amount that must match the directions on the medication label, and time/s to be given.

____Please do not instruct staff to administer "as-needed". Clearly list what symptoms and signs to look for that require administration of the medication.

To be completed by parent/guardian. Each medication per child requires a separate authorization form			
Medication Authorization for (Child's Name)		Medication Name (as it reads on the label):	
Dosage and times to be administered (per instructions on medication):		Route to administer (orally, intramuscular, inhaler, etc)	
Condition for which medication is being administered (if diagnosed allergies, please fill out page 2 "PRCS Food Allergy Action Plan):			
If dosage and times to be administered depend on symptoms, please list specific signs and symptoms here:			
Special instruction or side effects (if any):			
This original authorization is effective from: _____/_____/_____ until _____/_____/_____ (not to exceed 10 business days)			
I hereby authorize the Loudoun County Department of Parks, Recreation and Community Services personnel to give the medication as directed by this authorization. I, on behalf of myself, my executors, administrators, heirs, next of kin, and successors, herby covenant to hold harmless and indemnify the County and all of its officers, departments, agencies, agents and employees from any and all claims, losses, damages, injuries, fines, penalties and costs (including court costs and attorney's fees), charges, liabilities, or exposures, however caused, resulting from, arising out of, or in any way connected to assisting this participant with the use of medication. I have read and understand this HOLD HARMLESS AGREEMENT and by my signature for each medication permission I agree to its terms.			
Parent Signature:		Date:	
Parent Signature (for a one time short-term authorization renewal per program per year-effective dates of authorization must be updated):		Date:	New effective dates of authorization: __/__/__ until __/__/__

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Food Allergy Action Plan

Child's Name	Child's DOB:
Child is Allergic to:	

Check only one box for type of reaction (mild, severe or special situation) if exposed to allergen, then select or write in symptoms that apply:

□	**MILD REACTION (check symptoms that apply)** □itchy nose □sneezing □itchy mouth □a few hives □mild stomach discomfort/nausea **Other/s not listed:**
	Actions for PRCS staff to take if child is exhibiting symptoms of a mild reaction to listed allergy:
□	**SEVERE ALLERGIC REACTION (check symptoms that apply)** □shortness of breath □wheezing □skin color is pale or has bluish color □weak pulse □fainting or dizziness □tight or hoarse throat □agitation □feeling of "doom" □trouble breathing or swallowing □vomiting/diarrhea □many hives or redness over body □coughing □confusion, altered consciousness □swelling lips or tongue that bother breathing **Other/s not listed:**
□	**SPECIAL SITUATION-**Child has EXTREME severe allergy to food(s) and requires an epinephrine immediately if exposed to allergen, even if symptoms are mild

Please select all steps applicable for PRCS Staff to take if your child is exposed to listed allergy:

□	Administer antihistamine as prescribed on PRCS medication authorization form, call parents
□	Administer antihistamine as prescribed on PRCS medication authorization form, call parents. Monitor child. If symptoms worsen, inject epinephrine as prescribed on PRCS medication authorization form, call 911, call parents
□	Inject epinephrine immediately, noting time given, call 911, call parents
□	Inject epinephrine immediately, noting time given, call 911, give antihistamine if prescribed, call parents
□	Other:

I, (parent/guardian)_____, have reviewed and discussed the above Food Allergy Action Plan with my child's physician, and authorize Loudoun County Parks, Recreation and Community Services staff to follow the plan as documented on this form, should my child be exposed to the above listed allergy.

Parent/Guardian Signature: **Date:**

Physician Signature: **Date:**

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