Loudoun County Parks, Recreation, and Community Services

Long Term Medication Authorization Form For Prescription and Non-prescription Medications **INSTRUCTIONS: <u>Complete a separate form for each medication</u>**

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any other **long-term medication authorizations** (those lasting longer than 10 working days).
- **PRCS Food Allergy Action Plan**- must be completed by a physician if your child has a diagnosed food allergy. This plan must include steps to be taken in the event of a suspected or confirmed allergic reaction.

A. 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 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 one year)			
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:	
B. To be completed by child's physician. Each medication per child requires a separate authorization form			
I certify that it is medically necessary for the medication listed above to be administered to (child's name)_____ for a duration that exceeds 10 work days. **PLEASE SELECT WHICH BOX APPLIES:** □The above listed child has no known allergies and no Food Allergy Action Plan is needed at this time. □The above listed child has a known or suspected food allergy. An attached **Food Allergy Action Plan** has been discussed and reviewed with the parent/guardian.			
Physician Name:	Physician Signature:	Date:	

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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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