DEERFIELD PARK DISTRICT

MEDICATION DISTRIBUTION POLICY

Statement of Purpose:

The Deerfield Park District discourages dispensing prescription medicine to children participating in park district programs; leaving the primary responsibility to parents and guardians to dispense prescription medication to children. However, the Deerfield Park District recognizes it may be necessary in certain circumstances for children participating in park district programs to take prescription medication during program hours.

Limits of Assistance

The park district is not a health care provider and does not hold itself out as such. Park district responsibilities are limited to accepting medications, and making reasonable efforts to provide the prescribed doses at the prescribed intervals to the best of its ability.

Direct responsibilities do not include direct administration of medication including measuring of dosage or preparation of medication beyond that of counting tablets or pouring liquids into a pre-measured container made specifically for that use. Any medications not delivered in original packaging or in packaging not easily read will be rejected by the park district. Written instructions must be clearly marked, specifying dosage, method of administration and discontinuance date.

Request Procedure

All requests by parents and legal guardians for dispensing prescription medications to children participating in a park district program should be directed to the Program Supervisor to determine the feasibility of the park district complying with the request. If possible, this request should be completed prior to registration for the program. The Program Supervisor is the approval authority for allowing children requiring the administering of prescription medications into a park district program. A written order and waiver of liability from the parent and/or guardian requesting the administration of medication by park district staff is required prior to medication being dispensed.

Approved by the Board of Park Commissioners: 3-21-96

Revised by the Board of Park Commissioners: 10-9-97, 9-20-01

Deerfield Park District
Dispensing of Medication
Procedures

I. Parental Procedures and Responsibilities

The parent/guardian **must**:

1. Complete the *Permission to Dispense Medication/Waiver and Release of All Claims* form;
2. Complete the background information on the *Medication Dispensing Information* form;
3. Have physician complete and sign the *Medication Dispensing Information* form:
4. Deliver all medication to the agency office in the original prescription bottle or in clearly marked containers which include the person's name, medication, dosage, and time of day medication is to be given;
5. Verbally communicate with agency staff regarding specific instructions for medication.

II. Staff Medication Dispensing Procedures

Agency program staff **must**:

1. Ensure that the Permission and Waiver to Dispense Medication Form and Medication and Dispensing Information Form are fully completed and signed by the parent/ guardian and physician prior to the dispensing of any medication;
2. Ensure that only authorized staff accept medication which may include the executive director, superintendent of recreation, safety coordinator, program coordinator, recreation specialist, registrar, secretary or other designated staff;
3. Verbally communicate with the parent or guardian regarding any specific instructions regarding the dispensing or storage of the medication. It is also the responsibility of the authorized staff who receives medication to properly store medication in a locking cabinet or in a refrigerator as needed. **It is extremely important that stored medication is out of the reach of other patrons and particularly children.**
4. Obtain copies of all waivers, internal procedures, medical information forms, and medication logs when obtaining the prescription medication to be transported to the program site. All medication stored at a program site must be secured and only available to authorized program staff.

Medication Dispensing Information

This form must be completed for each program session or when medication changes.

BACKGROUND INFORMATION:

Participant's Name:_____ Age:_____

Address:_____

Parent's/Guardian's Name(s)_____

Daytime Phone:_____ Other Phone:_____

Program Name:_____

Doctor's Name:_____ Phone:_____

MEDICATION INFORMATION: (This section to be completed and signed by physician)

1. Name:_____ Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

2. Name:_____ Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

3. Name:_____ Dose:_____ Time:_____

Dispensing& Storage Instructions:_____

_____

Possible Side Effects:_____

_____

PHYSICIAN'S SIGNATURE _____

_____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

_____ _____

Signature of Parent or Guardian **Date**

Deerfield Park District
Permission to Dispense Medication
Waiver and Release of All Claims

The Deerfield Park District will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian and physician. The agency's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM:_____ DATE:_____

I _____ the parent/guardian of _____
(Print Name)

(Print Name)
give permission to the staff of the Deerfield Park District **to administer to my child**

_____
(Name of Medication)

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information:

PARTICIPANT'S NAME:_____

NAME OF MEDICINE AND COMPLETE DOSAGE INSTRUCTIONS:

_____

_____

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Deerfield Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

WAIVER & RELEASE OF ALL CLIAMS

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In consideration of the Deerfield Park District administering medication to my minor child, I do hereby fully release or discharge the Deerfield Park District, and its officer, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

_____ _____

Signature of Parent or Guardian **Date**

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

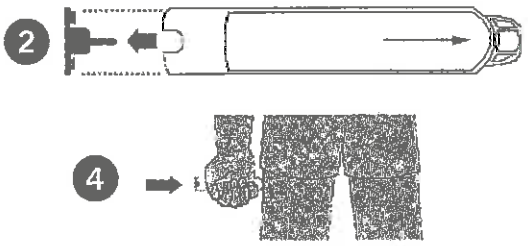
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

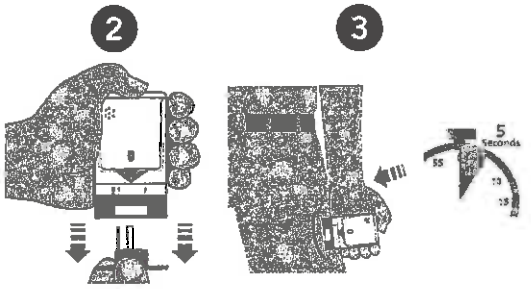
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

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