AYCC Childcare & Camps

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ALFOND YOUTH & COMMUNITY CENTER

Last Name	First Name	
DOB	Epi Pen _____	Inhaler _____

My child has permission to carry his/her Epinephrine Auto-Injector and/or Asthma Inhaler while in attendance of an AYCC childcare/camp.

Parent/Guardian Name _____Phone _____

Signature _____ Date _____

A Licensed Medical Professional must complete the bottom section of this form.
OR
A copy of a recent Asthma Action Plan or Anaphylaxis Emergency Care Plan should be submitted to the Childcare/Camp Director.

Name of Medication(s)	
Date of Medication Order	
Route & Dosage of Medication	
Frequency & Time of Medication Administration/Assistance	
Specific recommendations for administration (what type of symptoms would indicate need for medication?)	
Diagnosis and any other medical conditions requiring medication.	
Any special side effects, contraindications and adverse reactions to be observed?	

I hereby verify that _____ has a valid prescription and the knowledge and skills to safely possess and use the following medication while in the care of the AYCC.

_____ _____ _____ _

Physician's Office Name | Office Address | Phone

_____ _____ _____

Physician's Name | Physician's Signature | Date