Olympic Educational Service District 114
105 National Avenue North, Bremerton, Washington 98312
(360) 478-6887 ● 1-800-201-1300 ● FAX (360) 405-5808

CLASSROOM ACCOMMODATION PLAN

_____ (staff) will administer medication to children in the classroom/center only with written and signed instructions from the parent and health care provider. Medication may be given only for chronic or non-communicable conditions. Medication must be in the original container with the pharmacy label intact. **PLEASE PROVIDE ALL OF THE FOLLOWING INFORMATION.**

Child's Name: _____ **DOB:** _____ **Gender: M F** **Site:** _____

This Plan is for Health Concern:

If non-allergy chronic illness, Please list child's early warning signs and symptoms:	**If allergy, please circle the following symptoms that the child has previously experienced**: Mouth/throat: itching, swelling of lips tongue mouth throat Skin: hives swelling Gut: nausea cramps vomiting diarrhea Lung: shortness of breath coughing wheezing
Medications: Is the child on medication?	Yes No
Does medication need to be given at school?	Yes No
Is the medication needed during 72 hr. emergency?	Yes No

Emergency Plan for Severe Allergic Reaction:

☐ **Administer other prescribed medication _____(see below for instructions)**

☐ **Administer Epi-pen immediately**

If emergency medications(s) are administered: 1) Call 911; 2) Call parent; 3) Stay with child.

Medication	Dosage Route	Dosage Amount	Dosage Time /Frequency of repeat	Possible Side Effects	Medication Exp. Date

Non-medication Treatment Plan:

Plan Start Date: _____Plan Stop Date:_____

Parent Signature _____Date _____

I authorize Head Start/ECEAP staff to give my child the above named medicine in the dosage and at the time listed.

I also give my permission for an exchange of information between Head Start/ECEAP and the licensed health care provider listed below.

Physician Signature _____Date_____

Printed Name _____Phone_____

Teacher: _____Date_____ Teacher_____ Date_____

Family Advocate: _____ Date_____ Other _____Date_____

*If there are questions or concerns, please contact*_____

Administration/Observation Log on Back

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MEDICATION ADMINISTRATION RECORD

For Child Name _____ **DOB** _____

Complete the following when medication is **received** in the classroom/center:

Date: _____ **Signature Parent/Guardian** _____ **Staff Initials** _____

Complete the following when medication is **discontinued/returned** to parent/guardian:

Date: _____ **Signature Parent/Guardian** _____ **Staff Initials** _____

Medication Administered	Date/Time	Dosage	Route	Name of person administering medication	Signature of person administering medication	Comments/ Observations