Waiver Request: <u>Administration of Emergency Medications</u> **Rev.8/16/2011**

Epinephrine Auto Injector(in combination with diphenhydramine), **Asthma Inhalers and Nebulizers**

Program Name: _____ Facility ID Number: _____

☐The program named above is requesting a waiver for the following regulations **as they relate to the use of epinephrine auto injectors, asthma inhalers and nebulizers only:**
☐The program named above is also requesting a waiver to administer diphenhydramine **(**Benadryl) when a physician's or health care provider's orders state that Benadryl must be administered in combination with the auto injector to combat anaphylactic shock.

Check the regulations below that apply:
☐**School-Age Child Care** 414.11(a)(5), 414.11(a)(6), 414.11(a)(7), 414.11(d)(2), 414.11(g)(4), 414.11(g)(5)(i), 414.11(g)(5)(iii), 414.11(g)(14), 414.11(g)(17)
☐**Group Family Day Care** : 416.11(a)(5), 416.11(a)(6), 416.11(a)(7), 416.11(f)(2), 416.11(j)(4), 416.11(j)(5)(i), 416.11(j)(5)(iii), 416.11(j)(14), 416.11(j)(17)
☐**Family Day Care:** 417.11(a)(5), 417.11(a)(6), 417.11(a)(7), 417.11(f)(2), 417.11(j)(4), 417.11(j)(5)(i), 417.11(j)(5)(iii), 417.11(j)(14), 417.11(j)(17)
☐**Day Care Center:** 418.-1.11(a)(2), 418-1.11(a)(3)(iii), 418-1.11(a)(4)(iii), 418-1.11(b)(2), 418-1.11(f)(2), 418-1.11(j)(4)(i), 418-1.11(j)(4)(iii), 418-1.11(j)(13), 418-1.11(j)(16)

I agree to the following terms:
1. An I*ndividual Health Care Plan* must be developed for the child with the potential emergency condition. This form (OCFS-LDSS-7006) can be found on the website at: http://www.ocfs.state.ny.us/main/childcare/childcare_forms.asp or requested from your licensor or registrar.
2. The child's health care provider must issue a standing order and prescription for the medication. (Form OCFS-LDSS-7002 can be found at: http://www.ocfs.state.ny.us/main/childcare/childcare_forms.asp.)
3. The parent/guardian must approve, in writing, the administration of the medication as prescribed by the health care provider and keep medications current (Form OCFS-LDSS-7002).
4. All provider/caretakers administering an emergency medication must be instructed on the use of the auto Injector or inhaler. The instruction must be provided by the parent, guardian or child's health care provider. A caretaker who has been instructed on the use of the auto injector or inhaler must be present during all hours the child with the potential emergency condition is in care.
5. The provider/caretaker administering the auto-injector (and Benadryl) or asthma medication must be at least 18-years-old.
6. The waiver request must be signed and mailed, emailed or faxed to the program's OCFS licensor or registrar for review and approval. Additional waiver forms can be found at: http://www.ocfs.state.ny.us/main/childcare/mat/matwaiver.asp or requested from your licensor or registrar.
7. The provider/caretaker must submit verification of certification in Cardiac Pulmonary Resuscitation (CPR) training and first aid with this waiver request. CPR and first aid certification must be kept current. The person instructed to administer the emergency medication does not have to be the same person trained in CPR or first aid; however, the person with CPR and first aid training must be present whenever the child(ren) with the medical condition that may necessitate the emergency medication is on site.
8. If this waiver concerns the use of an epinephrine auto injector, the provider/caretaker must immediately contact 911 after administration of epinephrine.
9. If this waiver concerns the use of an inhaler or nebulizer for asthma, a provider/caretaker must call 911 if the child's breathing does not return to normal functioning after use.
10. The Division of Child Care Services recommends that persons who will be administering the epinephrine injector or asthma inhaler attend a course in its use. Persons who attend any courses associated with this waiver will receive training credits toward the 30 hours of mandated training required every two years.

Checking the appropriate boxes and signing this waiver request signifies that you will comply with the language and conditions set forth in the paragraphs above.

Provider's Signature _____ Date_____

Provider's Name: (Print)_____

Regional Office Manager's (or Designee's) Signature_____ Date_____