Lakewood City Schools
Community Recreation and Education Department

Child Information Form

Camp-Can-Do/S.T.O.P.

Children will NOT be accepted at camp without a completed CHILD INFORMATION FORM on file.

PARTICIPANT INFORMATION (PLEASE PRINT)

NAME_____ SEX: M F

ADDRESS: _____
House # Street City Zip

HOME PHONE NUMBER: _____

BIRTHDATE:_____ AGE: _____ CURRENT GRADE: _____ SCHOOL: _____

Please state any additional funding for camp (ie MRDD, School District) and amount:

Funding Source:_____ Amount:_____

Please circle which camp your child will attend:

Camp-Can-Do (Ages 5-13) **S.T.O.P (Ages 14-22)**

Please circle which session(s) your child will attend:

Session 1 CCD	**Session 1 S.T.O.P**
Session 2 CCD	**Session 2 S.T.O.P**
Session 3 CCD	**Session 3 S.T.O.P**
Session 4 CCD	**Session 4 S.T.O.P**

My Child's T-shirt size is (please circle): YM YL AS AM AL XL
I understand each child will receive a T-shirt to wear on field trips.

SECTION I: EMERGENCY CONTACTS

EMERGENCY PHONE NUMBERS

Mother/Guardian Name:	Father/Guardian Name:
Mother/Guardian Cell/Pager:	Father/Guardian Cell/Pager:
Mother/Guardian Work:	Father/Guardian Work:

Emergency Contacts: List the name(s) of *other local persons* who you want to be contacted in the event of an emergency or illness if the parent/guardian cannot be reached. Persons listed should be able to assist in locating the parent/guardian and at least one person listed must be able to take responsibility for the child in cases where the parent/guardian can not be located.

Name:	Name:
City, State, Zip Code:	City, State, Zip Code:
Telephone Number:	Telephone Number:
Relationship to Child:	Relationship to Child:

COMPLETED FORM DUE JUNE 1

SECTION 2: CHILD'S MEDICAL INFORMATION

Name of Physician/Clinic Hospital: Physician Phone:

Name of Dentist: Dentist Phone:

Hospitalization Insurance:

Name and dosage of any medication taken on a regular basis*:

name ***dosage***

****Please complete separate permission to administer medication sheet if medication is needed during Camp-Can-Do/S.T.O.P hours.***

Allergies (food, medication, & environmental) and precautions, reactions, and treatment:

Medications, food supplements, modified diet currently being administered:

Please note any special needs your child has or services he/she requires (i.e. AD/HD, Autism, Diabetes, sun sensitivity, etc.)

Chronic Physical Problems:

Any additional health or enrollment information you feel we should know about your child:

SECTION 3: EMERGENCY AUTHORIZATION

I give the Lakewood Board of Education, Lakewood Community Recreation and Education Department, my permission to have my child transported to (Hospital or Clinic) for emergency medical care or to (Dentist, if applicable) for emergency dental care, or to the nearest available source of assistance.

☐ **YES** ☐ **NO**

SECTION 4: AUTHORIZATION FOR RELEASE

I hereby authorize the Lakewood Community Recreation and Education Department and Camp-Can-Do/S.T.O.P. to release my child to all individuals listed in Section 1: Emergency Contacts and to the following individuals. In addition, I understand that for safety purposes, a photo identification will be requested for verification purposes.

Name: Name:

Relationship: Relationship:

Telephone Number: Telephone Number:

Denial of Authorization for Release

Name: Name:

Relationship: Relationship:

I HEREBY authorize the Lakewood Community Recreation and Education Department to allow my child, to participate in all Camp-Can-Do/S.T.O.P. activities including but not limited to field trips, swimming, arts and crafts, playground and park activities.

I HEREBY acknowledge that I am responsible for understanding the information in the Lakewood Community Recreation and Education Department Camp-Can-Do or S.T.O.P. Parent Handbook as they relate to my child's enrollment in the program. I HEREBY agree to comply with all procedures, policies, and conditions contained in the Parent Handbook, and I understand that my failure do so may result in termination of my child's participation in the program. Copies of the Parent Handbook can be found at the Recreation Department or online at www.lakewoodrecreation.com.

By registering for any Lakewood Community Recreation and Education Department program, registrants agree to the Lakewood City Schools Community Recreation and Education Department Program Registration Wavier & Consent Policy. A copy of the policy is available at the Lakewood Community Recreation and Education Department, in the Community Education seasonal booklet, or online at www.lakewoodrecreation.com.

PARENT/GUARDIAN SIGNATURE Date

COMPLETED FORM DUE JUNE 1

CAMPER CARE QUESTIONNAIRE

ALL INFORMATION MUST BE COMPLETED. PLEASE USE ADDITIONAL PAPER IF NEEDED.

Camper's Name _____Nick Name _____

Type of Disability _____

ANY SPECIAL CONCERNS/RESTRICTIONS?

_____

_____

For transportation, does your camper use a wheelchair? YES NO

Does camper need 1:1 supervision? If so, please explain

_____

_____

LANGUAGE AND COMMUNICATION: Please check all that apply

___ Uses sign language ____ Use Communication Board
___ Has difficulty speaking ____ Has difficulty being understood
___ Understands verbal instructions ____ No Communication Needs

Please describe special words and phrases used at home, if campers use eyes for yes/no, or other techniques

COMMENTS:_____
_____

EQUIPMENT: Please check all that apply

____ Able to walk alone ____Wheelchair/Manual
____ Wheelchair/Power ____Needs assistance pushing wheelchair
____ Crutches or cane ____Walker
____ Hearing Aide ____ Eyeglasses
____ Braces

Please describe frequency of use of appliances. Please do not send appliances to camp if the camper does not currently or routinely use.

COMMENTS:_____
_____

PERSONAL CARE: Please answer all questions by checking either YES or NO

Uses toilet independently YES___NO___ Needs toilet reminders YES___NO___
Dresses Independently YES___NO___ Wears diapers YES___NO___
Needs lifted onto toilet YES___NO___
Needs help with menstrual cycle care YES___NO___

******PLEASE BE SURE TO PROVIDE ENOUGH DIAPERS/DEPENDS AND UNDERGARMENTS. WE WILL NOT PROVIDE THESE ITEMS!**

EATING HABITS: Please check all that apply
___Needs to be fed ___Needs food cut
___Needs help drinking ___Difficulty swallowing
___Special equipment (explain how to use)_____
___Food allergies (what food)_____
___Special diet, food restrictions, etc.
___Other_____

SOCIAL CONCERNS: Please comment about behavior and social skills (reactions to frustration, group participation, peer relations, does camper hit, bite, etc.)

_____

_____

_____

SPECIAL INTERESTS AND SKILLS:
Camper's Favorite Food: _____ Camper's Favorite Snack:_____
Camper's Favorite Sport: _____ Camper's Favorite TV show: _____
Camper's Favorite Movie: _____ Camper's Favorite Book: _____
Camper's Favorite Song: _____

Camper is happiest when: _____
Camper gets angry when: _____
When the camper has done something good, a great reward would be: _____

ADDITIONAL INFORMATION: Please comment about any additional behavior, like/dislikes, or interests that the Camp-Can-Do or S.T.O.P. staff should know about your camper:
COMMENTS: _____
_____
_____

PLEASE READ CAREFULLY: I give consent for my child to participate in the activities of Camp-Can-Do or STOP, with any restrictions noted on this form.

_____

Signature of Parent/Guardian Printed Name Date

Lakewood Community Recreation and Education Department

Physicians' Questionnaire

Name of Child: _____ Date: _____

Address: _____ Age: _____

Phone: _____

The above-named child will be participating in a special education program which consists of instructional activities such as developmental skills, simple games and swimming, In order for the instructor to structure an individual program of activitiy within the needs, capabilities and limitations of the child, we would appreciate information relative to the questions listed below.

Description of child's medical condition: _____

Will water activities be of any harm to the applicant? _____

What restrictions in terms of physical activity should be observed for this child? _____

In my opinion, the above named boy/girl can participate in this program in accordance with his/her medical condition and restrictions described above.

_____

Signature of Physician

_____

Address of Physician

_____

Phone Number

Please return this form to the Lakewood Community Recreation and Education Department by June 1st.

PARENT REQUEST AND AUTHORIZATION TO ADMINISTER A PRESCRIBED AND NON-PRESCRIBED MEDICATION/DRUG OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED AND NON-PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ use or receive non-prescribed (over-the-counter) medication
*** Any non-prescription drug requires only a parent signature.**

Medication: _____
Dosage: _____Time to be administered: _____
Specific Instructions: _____

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

in accordance with the authorized prescription.

B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent***** Date

_____ _____
Home Telephone Work Telephone

*Parent, guardian, or other person having care or charge of the student.

LICENSED PRESCRIBER'S STATEMENT

To the Prescriber:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student (specify the name of the drug) _____
_____

Date the administration of the drug is to begin _____

Date the administration of the drug is to cease _____

Specify the dosage of the drug to be administered, and the times or intervals at which each dosage of the drug is to be administered _____

_____

Specify any special instructions for administration of the drug, including sterile conditions and storage
_____

_____

Report the following side effects (i.e., severe adverse reactions) to my office immediately _____

_____

_____

Prescriber's Signature _____ Telephone _____

Printed/Typed Name _____ Date _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

_____
Principal

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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 allergens:_____

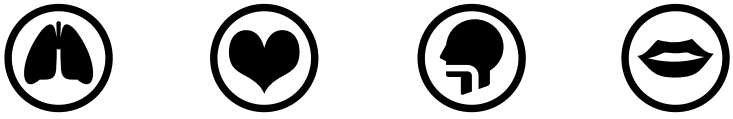
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

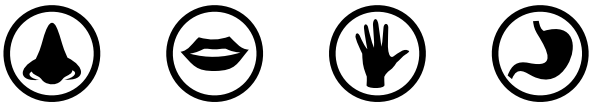
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or 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 or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

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

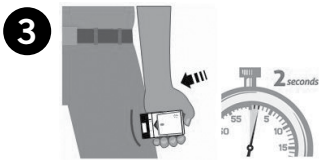
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

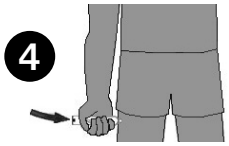
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



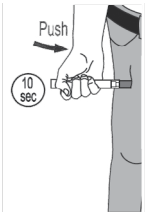
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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 worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020