

Lakewood City Schools
Community Recreation and Education Department

Children will NOT be accepted on the day of camp without a completed Child Information Form on file.

PARTICIPANT INFORMATION (PLEASE PRINT)

NAME: _____

SEX: **M** **F**

ADDRESS: _____

House #	Street	City	Zip
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HOME PHONE NUMBER: _____

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

PLEASE LIST ANY MEDICAL CONDITIONS/ALLERGIES/MEDICATIONS: _____

T-SHIRT SIZE (ADULT) SMALL MEDIUM LARGE X-LARGE

INSTRUMENT _____ PLAYING FOR HOW MANY YEARS? _____

PARENT/GUARDIAN NAME (PLEASE PRINT): _____

EMERGENCY PHONE NUMBERS:

MotherGuardian Cell/Pager: _____

Mother/Guardian Work: _____

Father/Guardian Cell/Pager: _____

Father/Guardian Work: _____

Other: _____

Please return form by June 1

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 Waiver & 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 _____



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

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:

School Nurse Reviewed:

Date:

Date:

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

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

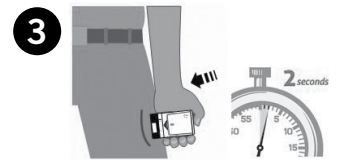
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

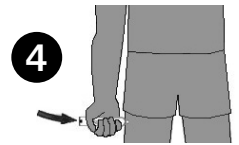
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



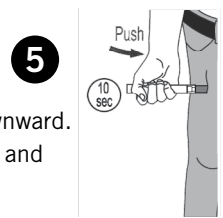
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENALINE®), 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: _____