

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)

**SEX:**    M                      F

**ADDRESS:** \_\_\_\_\_

House #	Street	City	Zip
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**CURRENT GRADE \_\_\_\_\_ SCHOOL: \_\_\_\_\_**

**BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **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](http://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

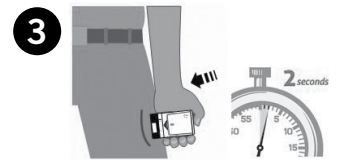
Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

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

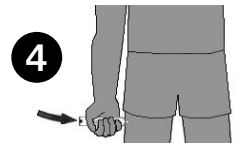
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



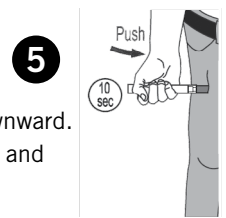
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.



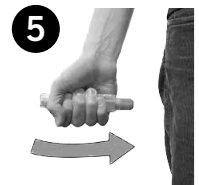
## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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: \_\_\_\_\_