Dear Families,

Your child has been identified as having an allergy or asthma. Families are required to complete an Allergy Action Plan and/or an Asthma Action Plan depending on the needs of their child. We feel these forms detail the best procedures to follow in case your child has an allergic or asthmatic reaction while at school.

Please complete the attached forms and return it to the school office at your earliest convenience.

1. **Parent Questionnaire**
2. **Allergy Action Plan** (and/or) **Asthma Action Plan** (completed in conjunction with a physician)
3. **Medication Consent Form**

If your child has an **ALLERGY** we ask that you supply SLC with the following:

- Two small photos of your child (passport photos are ideal).
- Two up-to-date Epi-Pens (if your child has been prescribed one).
- Attach an allergen-notification to your child's lunch box (any kind of sticker will do).
- Other prescribed medication that might be given during an allergic reaction (like Benadryl, Epi-Pen, etc.)

If your child has **ASTHMA**, we ask that you supply SLC with the following:

- Two small photos of your child (passport photos are ideal).
- All necessary medication (Antihistamine, Inhaler, Benadryl, etc.)

If your child's allergy or asthma is not life threatening, and your child will not be taking any medication for the condition at school a parent/guardian must sign the Emergency Health Care Plan waiver.

Sincerely,

The SLC Governing Board
The SLC Administrative Team

Questionnaire for Parents/Guardians of a Child with Asthma

Childs Name:	**DOB:**

1. How long has your child had asthma?_______________________________________
2. Please rate the severity of his/her asthma (circle one): **Not severe** 1 2 3 4 5 **Severe**
3. What triggers asthma in your child? (Things that cause wheezing) Check all that apply:

- ☐ Weather (cold, windy, rain)
- ☐ Illness
- ☐ Foods
- ☐ Exercise
- ☐ Tiredness/Emotional Factors
- ☐ Cigarette or other smoke
- ☐ Chemical odors
- ☐ Environmental Factors: Pollen, Mold, Dust, etc.
- ☐ Other: ____

4. What are the early signs and symptoms of an attack?_____________________________

   ____

5. Is medication prescribed for the condition? ☐ Yes ☐ No
6. What is the name of the medication? ____

____

7. Will the medication need to be given at the center? ☐ Yes ☐ No
   (If yes, please complete the Physician <u>and</u> Parent Consents to Administer Medication)
8. Has your child had any side effects from the asthma medication? ☐ Yes ☐ No

   If yes, please describe:____

9. Has hospitalization been needed in the past for asthma attacks? ☐ Yes ☐ No
   If Yes, please explain (when, how often, etc.) ________________________________

   ____

Revised 09/2012 LMS

10. Does your child know she/he has asthma? □ Yes □ No

11. Does your child usually tell an adult when she/he is having a reaction? □ Yes □ No

12. Will your child's activity need to be modified while at school? □ Yes □ No

    If yes, what is/are they?____

13. What do you usually do when your child has a reaction? ________________________

____

The Usual Treatment For A Severe Asthma attack Is To:

- Administer prescribed medication per written doctor's orders
- Notify Parents/guardians:

  Students Home phone #:

  Mother/guardian name:______________________phone:_____________________

  Father/guardian name:______________________phone:_____________________

Name of Doctor:_____________________Doctor phone:____________________________

Where does your child receive his/her asthma care (name of clinic):_____________________

Parent Signature: ____ **Date:** ___________

- *This information should be documented on the Child Enrollment Status form*
- *This information should be shared with the education & lunch and learn staff*

Asthma Action Plan

Child's Name ____ **Child's Date of Birth** ____________________

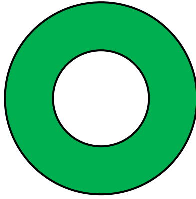
Doctor's Name and Number ____

Category of Severity–Check one:

☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

---

CONTROLLED
No symptoms.
Breathing is good.
This is where your child should be every day.



Green Zone Action Steps

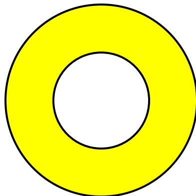
1. Avoid triggers that bring on your child's asthma (smoke, cold weather, allergens and infections).

2. Take ____ 10-15 minutes before exercise *if needed.*

3. Take your daily Green Zone maintenance medicines as follows:
____
____
____

These medicines are used to control and prevent asthma symptoms. Do not stop them without talking to your child's doctor.

CAUTION
Coughing, wheezing, runny nose, watery eyes.
Take action to get your asthma under control.



Yellow Zone Action Steps

1. Tell an adult.

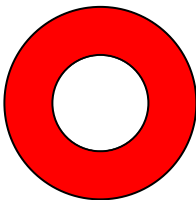
2. Give __________________________________every _________ hours until your child returns to the Green Zone (no symptoms).

3. *Always* check your child's breathing after giving rescue medicine.

4. Keep taking your Green Zone maintenance medicines

Let your child's doctor know if your child drops into the Yellow Zone more than once a week or if they stay in the Yellow Zone 24-48 hours. Your child's Green Zone maintenance medicine may need to be changed. Examples of rescue medicines are albuterol (proventil or ventolin) and maxair.

EMERGENCY
Chest being sucked in (retractions).
Nostrils flaring. Medicine not helping.
Breathing hard and fast. Activity level down.
Your child's asthma symptoms are serious!



Red Zone Action Steps

1. Tell an adult.

2. Give ____________________________ immediately and check your child's breathing.

3. If your child is not back in the Yellow/Green Zone, repeat above step every __________________ for a maximum of ______________________
____

4. Call your doctor at ____________________to notify him or her of your Red Zone event.

OR

See your doctor right away if your child's lips or fingernails are blue or if they are struggling to breathe after taking their medicine.

Doctor's Signature: ____ **Date:** ___________

Clinic Stamp:

Medication Consent Form

To be completed by a Parent/Guardian

I, ______________________________, parent/guardian of ____________________________ request that the staff of School for Little Children administer the prescription or non-prescription medications listed below to my child. I agree and fully understand that SLC will not be responsible for any side effects, adverse reactions or medical emergencies that my child may experience as a result of taking the medication. I also understand that the person who will be administering the medication is not trained by a health care professional.

Child's Name:____________________________________ **DOB:**_________________________

Emergency contact: __________________________________ **phone**:______________________

Child's known allergies:____

Reason Child is taking the medication:____

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

Physician Name:_________________________________**Physician Phone:**___________________

- I give the SLC staff permission to speak to the prescriber above and to exchange information related to my child.
- I authorize SLC staff to administer the medication as specified to__________________

Parent Name_____________________________________

Parent Signature:__________________________________

Date:__________________________________