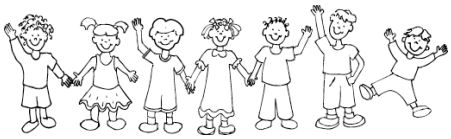


Play and Learn School

August 2018

Dear Parent,

You have informed us that your child has a medical concern. Enclosed are the forms, which need to be completed by both the Parent/Guardian and the child's health care provider. These forms are necessary in order for the staff or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

To help your student, please let us know of any changes in your child's medical condition or emergency daytime phone numbers.

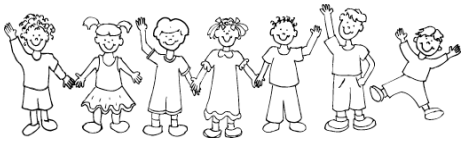
The following need to be returned to the office prior to the first day of school:

- Anaphylaxis Individual Emergency Care Plan
- Request for Medication Administration
- Allergy Questionnaire
- Asthma Action Plan (if necessary)

We look forward to working with your child this year.

Sincerely,

Jason Hoffman



Play and Learn School

Anaphylaxis Individual Emergency Care Plan

Child's Name	Date of Birth
Allergy to:	
Weight:	Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No
Does the child have a documented incident of anaphylaxis? ☐ Yes ☐ No	

Extremely reactive to the following: _____

Therefore:

☐ Give epinephrine immediately for **ANY** symptoms if there was a likely exposure.

☐ Give epinephrine immediately if there was exposure to the allergen, **even if no symptoms are noted**.

Otherwise

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, Hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, sweeling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

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1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 9-1-1
3. Begin monitoring
4. Give additional medications*
   If ordered:
   Antihistamine
   Inhaler (bronchodilator) if asthma

* Antihistamine and inhalers/ bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

›

1. **GIVE ANTIHISTAMINE IMMEDIATELY**
2. Stay with student; alert healthcare professional and parent
3. Dismiss student to care of parent or guardian
4. If symptoms progress (see above), USE EPHINEPHRINE

Medication/Doses:

Epinephrine: ☐ 0.15mg or ☐ 0.3mg ☐ May repeat dose in **10** minutes if symptoms continue.

Antihistamine: _____

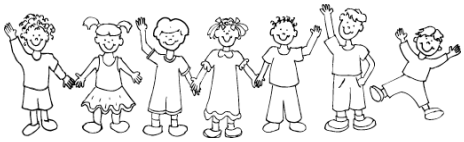
Other (e.g., inhaler- bronchodilator if asthmatic): _____

*Please note that by NJ State law only the administration of epinephrine can be delegated to a non-nursing school staff.

Contacts

Doctor:	Phone:
Parent/Guardian:	Phone:
Other Emergency Contact:	Phone:

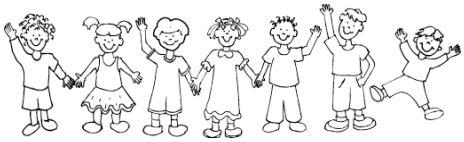
Parent/Guardian Signature:	Date:	Healthcare Providers Stamp
Healthcare Provider Signature:	Date:	



Play and Learn School

Allergy Questionnaire

Child's Name	Date of Birth
Allergies	
Date of child's last allergic episode?	☐ Never had an allergic episode.
Please describe what happened:	
Diagnosed by skin/blood testing? ☐ Yes ☐ No	
Has the child ever been hospitalized for an allergic episode? ☐ Yes ☐ No	
Does the child react when the above named allergen is eaten? ☐ Yes ☐ No Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy Throat ☐ Cough/Wheezing ☐ Anxiety/Restless ☐ Swollen Lips/Tongue Other:	
If this is a food allergy, do you plan to send lunch for your child each day? ☐ Yes ☐ No	
Can the child sit near someone eating the allergen? ☐ Yes ☐ No	
Can your child eat food processed in a facility that also processes the allergen? ☐ Yes ☐ No	
Does your child know what the allergen looks like and how to avoid it? ☐ Yes ☐ No	
Does the child react when he/she smells or inhales the above named allergen? ☐ Yes ☐ No Type of reaction: ☐ Stomachache ☐ Itching ☐ Hives ☐ Itchy Throat ☐ Cough/Wheezing ☐ Anxiety/Restless ☐ Swollen Lips/Tongue Other:	
Does the child react when he/she touches (or bitten/stung by) the above named allergen? ☐ Yes ☐ No Type of reaction: ☐ Rash ☐ Itching ☐ Hives ☐ Itchy Throat ☐ Cough/Wheezing ☐ Anxiety/Restless ☐ Swollen Lips/Tongue Other:	
Can the center send a letter home notifiying the classroom about the child's allergy in order to decrease the chances the allergen will be brought by a classmate? ☐ Yes ☐ No	
What do you do at home (accommodations, diet restrictions, substitutions)?	



Play and Learn School

Request for Medication Administration

In accordance with Play and Learn School policy, staff members are permitted to administer medication. Administration of medication at the center will only be done when it is impossible for parents to fulfill the recommended cycle of delivery. This is to be done only if medication has been prescribed by the child's health care professional who has noted diagnosis, medication, dosage and time. This includes any over the counter medications. In addition, a parent/guardian must sign the permission form below and return to the office. The permission form must be updated every school year.

The prescription must be in properly labeled pharmacy containers. Over the counter medications must be in the original, sealed container and accompanied by a health care professional's note. Medication must be brought to the office and picked up by a designated adult.

I understand that Play and Learn School and its employees or agents shall have no liability as a result of any injury arising from the administration of the medication listed below; and shall indemnify and hold harmless the school and its employees or agents against any claims arising out of administration of the medication.

If your child has a food allergy, asthma, or seizure disorder, this form must be filled out for each medication in addition to the action plans that have been developed for those medications. Forms are available in the school office.

Authorization is hereby given for medication to be administered in school to:

Child's Name		Date of Birth
Diagnosis		
Dosage	Frequency	Time to be Given
In the event of school trips, child may skip medication for the day? ☐ Yes ☐ No		

Healthcare Provider's Name (please print)		
Healthcare Provider's Signature		Healthcare Providers Stamp
Date	Phone	

Parent/Guardian Signature	Date