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children educated, enriched, and engaged

LINK 2024-2025
Registration Application, Permissions, & Liability Release

Please read and sign the following statement:

I, _____, the legal guardian, and/or parent of _____,
(Parent/Guardian name) (Child name)

declare that I have read and understand LINK Grinnell's Policies and Procedures as contained in this document as well as in the LINK Grinnell's Policies Handbook.

Signature: _____ Date: _____

Registration Information

Today's Date: _____ Preferred Start Date: _____

Child Information:

_____
First Name M.I. Last Name Preferred Name M F

_____
Date of Birth School Attending Grade(24/25)

_____
Street Address City State Zip

Parent/Guardian Information:

Parent/Guardian 1 Information:

Name: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Physical Address: _____

Parent/Guardian Employer: _____

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Parent/Guardian 2 Information:

Name: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Physical Address: _____

Parent/Guardian Employer: _____

Parents' Marital Status: _____
(Ex: Married, Single, Divorced, Separated, Deceased, Blended Family)

Siblings also enrolled/enrolling in LINK: _____

Schedule:

LINK Grinnell Hours

Afterschool:

PD/Full Day: 7:30am-6pm
Extended Day: 12/1pm-6pm
Afterschool Care: 3pm-6pm

Summer:

Full Day: 7:30am-5:30pm
SLICK Partial Day: 12pm-5:30pm

During the school year, parents/guardians are responsible for communicating any transportation needs to Davis Elementary to the Grinnell Newburg Community School District.

After-School ☐

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Professional Development/Other No-School Days ☐

Summer Program ☐

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Hours your child will likely attend**:** _____

☐ My child has been invited to and is attending SLICK

T-Shirt Size - Your child will be asked to wear a LINK provided t-shirt on field trip days. The design will be the same as previous years, so if your child needs a shirt, please let us know the size below.

Youth Small ☐ Youth Medium ☐ Youth Large ☐

Adult Small ☐ Adult Medium ☐ Adult Large ☐ Adult XL ☐

My child will wear the shirt they received last year ☐

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SPECIAL WEEKS SIGN-UP

Special week pricing is billed for the **full week** regardless of child attendance.

Check to Sign-up	Camp & Description	Age	Availability	Price per week
☐	June 10-14 LINK/Sport Camp Baseball & Softball, Soccer TBD	6–12		$175/week
☐	June 17-21 LINK/Sports Camp - Basketball	6–12		$175/week
☐	June 24-28 LINK Week of Tasting - Cooking	Entering 4th grade and older	Limited	$145/week
☐	July 15-19 LINK Week of Videography	Entering 5th grade and older	Limited	$145/week

About Your Child's Health

*If there are any allergies or medications, the necessary care plans/action plans also need to be completed with the enrollment packet

Child's Doctor's Name: _____ Doctor's Phone: _____

Doctor's Complete Address: _____

Child's Dentist's Name: _____ Dentist's Phone: _____

Dentist's Complete Address: _____

Health Insurance Company: _____

Policy Holder:_____ Policy _____ Number: _____

Known Allergies (including food & medications): _____

Does your child have any of the following:

☐ ADHD/ADD ☐ Depression ☐ Speech/Vision/Hearing Needs
☐ Autism Spectrum Disorder ☐ OCD ☐ PTSD
☐ Sensory Needs
☐ Anxiety Disorder ☐ ODD
☐ Other _____

If you responded yes to any of the above, please tell us more about how we can best accommodate your child: _____

List any conditions that may restrict or limit participation in activities, result in an emergency situation, or require medical updates or observation: _____

Immunizations

Is your child immunized? Y☐ N☐

*A copy of your child's immunization record or exemption must be submitted with these registration forms.

*If your child is not immunized, please read and sign the following statement:

I understand that should there be a suspected or real outbreak of any communicable disease, I may have to remove my child from LINK Grinnell's childcare until cleared by medical staff.

Parent/Guardian's Signature_____ Date _____

About Your Child's Safety

Please list anyone not previously listed who is authorized to pick up your child along with their contact number. I.D. will be required at the time of pick up. Indicate if the person listed may also be contacted in an emergency.

Name	Relationship to Child	Home Phone	Work Phone	Cell Phone	Emergency Contact?
_____	_____	_____	_____	_____	Y ☐ N ☐
_____	_____	_____	_____	_____	Y ☐ N ☐
_____	_____	_____	_____	_____	Y ☐ N ☐
_____	_____	_____	_____	_____	Y ☐ N ☐

Is there a court order prohibiting contact with your child by any person? YES ☐ NO ☐

If yes, please provide a photocopy of court order and prohibited person(s).

Name of prohibited person:

Relationship to child:

Is there any child custody order of which we need to be aware? YES ☐ NO ☐

If yes, please explain:

Is there a separation or divorce situation of which we need to be aware? YES ☐ NO ☐

If yes, please explain:

Names of persons who **MAY NOT** pick up your child. Please also provide photos:

Permission Form

1. I hereby give permission for my child to go on field trips arranged by LINK Grinnell staff. I understand that I will be informed in advance of any special field trips.

   Parent/Guardian Signature: _____ Date: _____

2. I hereby give permission for pictures and/or videos to be taken of my child in the LINK Grinnell program setting for general record-keeping and use in promoting LINK Grinnell. We understand that no financial benefits from the use of the photographs/videotapes are obligated to be paid to us.

   Parent/Guardian Signature: _____ Date: _____

Assumption of Risk

Participation in physical activities can involve motion, rotation, and height in a unique environment and as such carries with it a certain assumption of risk. The undersigned and the participant(s) choose to voluntarily enter upon said premises under the control of LINK Grinnell, knowing their present condition and knowing that said condition might become more hazardous and dangerous during the time the participant or the undersigned is upon said premises. The undersigned and the participant(s) voluntarily assume any and all risks of loss, damage, or injury that may be sustained upon said premises above. LINK Grinnell may, but shall not be obliged to carry insurance on the participant(s) and the undersigned or affect the terms of this release. In signing the release, the undersigned acknowledges:

a) That they have read thoroughly, understands completely the terms of Registration and Release, and signs it voluntarily.
b) That the undersigned signing either for themselves, or as Legal Guardian is, in fact, the true and legal guardian and has the consent of the participant(s).

Parent/Guardian Signature: _____ Date: _____

Liability Release Form

In consideration of allowing the previously declared participant(s) to begin participation in the LINK Grinnell child care activities, while on the premises and property of said program, the undersigned, for themselves, and/or being the legal and acting guardian of participant(s), acting for themselves and on behalf of the participant(s), release and hold harmless LINK Grinnell, its owners, employees, and agents of and from any and all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by the participant and/or the undersigned, while in or upon the premises which LINK Grinnell is conducted, or any premises under the control and supervision of LINK Grinnell, its owners, officers, employees, or agents or in route to or from any of the said premises, or while at any premises or place when activities sponsored by or participated in by LINK Grinnell, its owners, officers, agents, or employees.

Parent/Guardian Signature: _____ Date: _____

Transportation Release

I give my permission for my child to be transported either by LINK Grinnell transportation or by other commercial or public transportation for field trips.

Parent/Guardian Signature: _____ Date: _____

Swimming Release

I/we do [ ] do not [ ] give consent for _____ to take part in the water program at LINK Grinnell Summer, which includes the Grinnell Aquatic Center and the outdoor water activities on-site at Davis Elementary (slip-and-slides, water balloons, etc.). I have read the description of the program and am satisfied that it is adequately supervised. I take responsibility for medical costs should any occur. **Use of diving boards and slides will be determined by Grinnell Parks and Recreation Lifeguard Staff and LINK Grinnell staff.** Use of these items may differ from when your child attends the pool with you. Please respect our decision on this matter.

Parent/Guardian Signature: _____ Date: _____

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Parent Authorization for Emergency Treatment

Child's Name: Date of Birth:

In the event that my above-named child requires MEDICAL CARE OR MEDICAL SURGICAL TREATMENT and I am not available or cannot be reached, then I authorize LINK to seek such treatment and I hereby give my consent for medical and/or surgical treatment as may be required to:

Hospital Name: City:

Doctor's Name: Doctor's Phone:

In the event that my above-named child requires DENTAL CARE OR DENTAL SURGICAL TREATMENT and I am not available or cannot be reached, then I authorize LINK to seek such treatment and I hereby give my consent for dental and/or dental surgical treatment as may be required to:

Hospital Name: City:

Dentist's Name: Dentist's Phone:

The consent will be effective beginning (Date) _____ and continuing until the end of my child's enrollment in the program. The undersigned gives permission for LINK Grinnell owners, employees, and/or agents to seek emergency medical and/or dental treatment for the participant(s) in the event they are unable to reach any parent or guardian. The undersigned also agrees that they themselves will be responsible for any financial debt incurred by said action.

Parent's or Legal Guardian's Signature _____ Date _____

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Topical Treatments Consent

I authorize LINK staff to give my child, _____, the following topical medications/ treatments: (please check all that apply)

Sunscreen ☐

Insect repellant ☐

Dry skin lotion ☐

Petroleum jelly ☐

Other ☐

name & use guidelines _____

name & use guidelines _____

As a parent/guardian of the above, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at LINK Grinnell to apply a sunscreen product of SPF 30 or higher to my child(ren) as specified below when he/she will be playing outside during the months of May-August and between the daily times of 10am-4pm. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose, bare shoulders, bare arms, and bare legs. I have checked all applicable information regarding the type and use of sunscreen for my child.

☐ I do not know of any allergies my child has to sunscreen.

☐ I have provided sunscreen for my child that will be kept at camp.

☐ LINK Grinnell may use the sunscreen of its choice following the directions or recommendations printed on the bottle if the sunscreen I provide is not available.

☐ My child is allergic to some sunscreens. Please use only the following brand(s)/type(s) of sunscreen:

_____

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

_____

This form does **NOT** cover any prescription medicines. It does **NOT** cover any over-the-counter medicine that is given orally, such as Tylenol, Dimetap, etc. These require the medical consent form on the next page.

Child's Full Name: _____

Parent's or Legal Guardian's Signature: _____ Date _____

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Medication Consent

*This form must be completed for any Over the Counter medications like Tylenol, Halls, Ibuprofen, Benadryl, etc. If we do not have a medication consent form for any medication, we are unable to give any medication without prior authorization from a parent/guardian.

Child's Full Name:

Physician's Name and Phone Number:

Does your child take any **prescribed** medications?

Name of Medication(s):

Please give the medication listed above:

Amount:

Time:

Number of days or doses:

Name of Medication(s):

Please give the medication listed above:

Amount:

Time:

Number of days or doses:

Name of Medication(s):

Please give the medication listed above:

Amount:

Time:

Number of days or doses:

Parent's or Legal Guardian's Signature _____ Date _____

LINK Programming Fee Schedule

	Full Day	Field Trip Day (Summer)	Extended Day (early out)	Afterschool
Regular Fees	$28	$33	$15	$12
Partner Organization* (Summer Only)	$23	$28	N/A	N/A
Reduced Level 1 (Reduced Lunches)	$13.25	18.25	$8.75	$7
Reduced Level 2 (Free Lunches)	$8.75	$13.75	$6.25	$5
SLICK Partial Days (Summer Only) Reverts to above pricing when SLICK ends	N/A	$20	$15	N/A

A non-refundable annual registration fee of $75 (eligible for sliding fee scale) is due once the Executive Director has assigned a start date.

Fees noted above effective 1/1/2023.

LINK Grinnell does work with Child Care Assistance through DHS. A financial sliding fee scale is available upon request; the Reduced Fee Form must be completed and signed to qualify for the reduced fee.

A **late fee** for children picked up after the program end time (6:00 pm during the school year and 5:30 pm during the summer) will be charged at $5 per 15 minutes, per child. After three late pick-ups, program enrollment may be suspended or terminated.

All payments may be made through ProCare or via credit, check, or cash. Payments made by check should be payable to **LINK Grinnell**. Payment is due weekly, and may be pre-paid monthly. Program enrollment may be suspended for nonpayment of fees and/or communication avoidance. It is the parent's responsibility to check MyProcare.com for their current tuition amount. Parents without internet connection can receive "hard copies" of tuition statements and center communications. Inform the Executive Director if you need to be placed on our *Parent Print-Out List*.

Tuition Express forms must be filled out and kept on file at the LINK offices regardless of traditional payment method. If tuition is not paid after one month, then tuition will be processed through the Tuition Express system, along with a $10 late fee. A service fee of $10 will be charged for any returned checks and/or declined payments.

*Subject to change yearly. Inquire with the Executive Director and/or your employer.

I have read and understand the fees schedule as stated above. I acknowledge that non-payment of fees will result in suspension from program services.

☐ Please enroll me in automatic weekly payments

Parent's or Legal Guardian's Signature _____ Date _____

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Reduced Fee Form

Eligibility to qualify for the financial sliding fee scale is based on the qualifications of the free and reduced meal program with the student's local school district. For questions regarding eligibility, please contact your local Food Service Director in Nutrition Services. In Grinnell, please call Kim Sieck at **(641)-236-2668**.

_____ qualifies for ☐ free ☐ reduced
(Print Parent/Guardian's Full Name)

lunch program/school fees with the _____ School District, meeting the
(print school district name)

requirements for the financial sliding fee for my child(ren) to participate in the LINK After-School and/or Summer Program for the 2024-2025 academic year.

Please list the names of the child(ren) to be participating in the program for the academic year requesting access to the financial sliding fee scale.

_____ _____

_____ _____

Parent's or Legal Guardian's Signature

_____ Date _____

District FRL Eligibilty Official Signature

_____ Date _____

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Annual Statement Of Health

*May submit current copy of school physical information.

Child's Full Name: _____

General Physical condition: _____

Height _____ Weight _____ Heart _____ Chest _____

Throat _____ Neck _____ Abdomen _____ GU _____

Neurological System _____ Teeth _____ Skin _____

Head _____ Eyes _____ Ears _____

Allergies (Please state symptoms, causing factors, and any treatment center staff should administer)

_____

_____

_____

Has the child ever had convulsions?_____

Mark illnesses which the child has had:

☐ Frequent colds ☐ Mumps ☐ Whooping Cough ☐ Pneumonia
☐ Rubella ☐ Polio ☐ Ear Infections ☐ Chicken Pox
☐ Surgery: _____ Date: _____
☐ Other: _____

Are there any other physical conditions about which the LINK staff should be aware?

_____

_____

_____

Signature _____ Date _____

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

Symptoms of Anaphylaxis

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date

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:_____

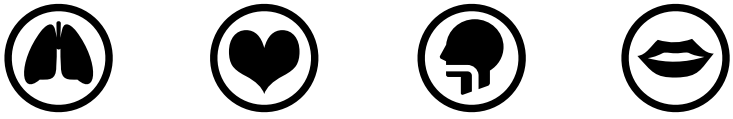
THEREFORE:

☐ 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

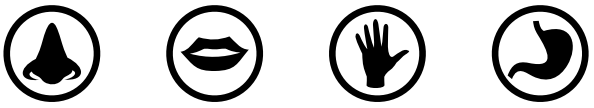
OTHER
Feeling something bad is about to happen, anxiety, confusion

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

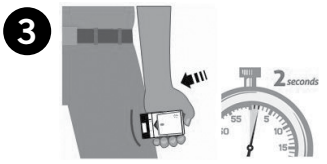
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

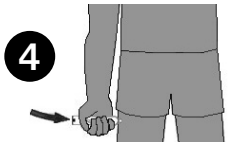
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



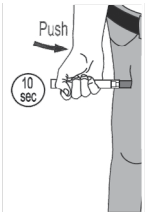
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY

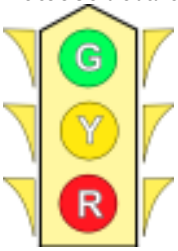
Asthma Action Plan

Asthma
Breathing easier in Iowa
The Iowa Asthma Control Program

www.idph.state.ia.us **(Press Firmly)**

Name	Date of Birth	Effective Date / / to / /
Doctor		Parent/Guardian
Doctor's Office Phone Number		Parent's Phone
Emergency Contact After Parent		Contact Phone

The colors of the traffic light will help you use your asthma medicines.



Green means **Go Zone!**
Use preventive medicine.

Yellow means **Caution Zone!**
Add prescribed yellow zone medicine.

Red means **Danger Zone!**
Get help from a doctor.

Pay Attention to Symptoms.

GO (Green)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____ to _____

Personal Best Peak Flow
_____

CAUTION (Yellow)

You have *any* of these:
- First sign of cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow from _____ to _____

DANGER (Red)

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue
- Trouble walking and talking

Peak flow from _____ to _____

Use these medicines every day

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

For asthma with exercise, take:

Continue with green zone medicine and ADD:

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK THEN CALL YOUR DOCTOR.

Take these medicines and call your doctor

EMERGENCY MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
COMMENTS:		

Get help from a doctor now! It's important!

Asthma is a potentially life threatening illness. If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- ❑ Chalk Dust
- ❑ Cigarette smoke & second hand smoke
- ❑ Colds/Flu
- ❑ Dust mites, dust, stuffed animals, carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests - rodents & cockroaches
- ❑ Pets - animal dander
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfumes, cleaning products, scented products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods:
  _____
  _____
  _____
- ❑ Other:
  _____
  _____
  _____

☐ This student is capable and has been instructed in the proper method of self-administering the medications named above (or attached prescription).

☐ This student is not approved to self-medicate.

Check asthma severity: ❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

PHYSICIAN SIGNATURE _____

PHYSICIAN STAMP

Produced by the Iowa Department of Public Health
Adapted from the NYC Childhood Asthma Initiative
Adapted from NHLBI

Funding provided through a cooperative agreement with the Centers for Disease Control and Prevention

Printed 2003

WHITE - School/Child Care Copy Pink - Family Copy Yellow - Doctor Copy

Child Name: _____ DOB_____ Monthly Medication Record: Month _____ Year _____

Child Known Allergies:

Parent Permission to give medicine: I give my permission for the child care business to give the following medicine(s) to my child.

Date:	Parent Signature Giving Permission:	Name of medicine on the label:	Medicine dose on the label:	Time of day medicine is to be given at child care:[1]	Route of medicine as on the label:	Possible side effects:	Required storage: ☐ Refrigerate ☐ Refrigeration not required
☐ Medicine is prescribed ☐ Medicine is doctor approved and authorization is on file at child care		Reason medicine needed:			Special instructions for giving medicine:[2] Beginning date for medicine: _____ Ending date for medicine: _____		

Date:	Parent Signature Giving Permission:	Name of medicine on the label:	Medicine dose on the label:	Time of day medicine is to be given at child care:	Route of medicine as on the label:	Possible side effects:	Required storage: ☐ Refrigerate ☐ Refrigeration not required
☐ Medicine is prescribed ☐ Medicine is doctor approved and authorization is on file at child care		Reason medicine needed:			Special instructions for giving medicine: Beginning date for medicine: _____ Ending date for medicine: _____		

Date:	Parent Signature Giving Permission:	Name of medicine on the label:	Medicine dose on the label:	Time of day medicine is to be given at child care:	Route of medicine as on the label:	Possible side effects:	Required storage: ☐ Refrigerate ☐ Refrigeration not required
☐ Medicine is prescribed ☐ Medicine is doctor approved and authorization is on file at child care		Reason medicine needed:			Special instructions for giving medicine: Beginning date for medicine: _____ Ending date for medicine: _____		

Parent/Guardian Permission to Contact Pharmacy and Physician: I give my permission for the child care business to contact my child's pharmacy and/or physician should a question arise or a situation occur that involves my child and the medication.
Name (print): _____Signature: _____Date: _____

[1] The time of day for the medicine needs to be consistent between home, child care and other programs where the child is located like school. Ask the parent when the medicine is given at home so medicine doses may be evenly spaced as ordered.

[2] The medicine may need to be given before meals, after meals, with food, with a specific liquid (water or milk). All instructions should be written on the medicine label or accompanying instructions. When in doubt, call the pharmacy where prescription medicine was dispensed.

Monthly Medication Record

Child Name: _____DOB: _____Child Known Allergies:_____

Attach Child Photo Here

Month _____ Year _____		Day of Month																													
Medicine, Dose and Route ↓	**Time of Day ↓**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Example: Amoxicillin 250 mg., 1 teaspoon, orally	10 am	*																													

* Sign your initials in the box showing the medicine was given. Use an "**A**" when a child is absent. Use an "**O**" when medication is *not given* for any reason. If not given inform the child's parent, document in the child's record the reason the medication was not given and that the parent was informed.

Instructions for using Medicine Record:

- First Column: Record the medicine name, dosage, and route.
- Second Column: Record the time(s) of day the medicine is to be given at child care. If the medicine is given more than one time a day, use a separate row for each time of day the medicine is to be given.
- Day of Month Column: The person who measures and gives the medicine must place their initials in the appropriate **row** (for time) and **column** (for date) that the medicine was given. Use columns numbered from 1-31 for the date.

Child Care Provider (staff) signature/initials: _____/_____ _____/_____

_____/_____ _____/_____ _____/_____

Iowa Poison Control Center: 1-800-222-1222

For questions about administering medications contact your local child care nurse consultant (CCNC) or Healthy Child Care Iowa at https://www.idph.iowa.gov/hcci