Welcome to
The UIC Children's Center

Attached you will find our enrollment packet. We ask that you complete all forms and return them to us **prior** to your child's first day. These forms help our teaching staff begin to get to know your child and better prepare to welcome her/him on their first day. Should you have any questions regarding the forms please don't hesitate to reach out and ask.

The Children's Center Parent Handbook can be found on our website www.childrenscenter.uic.edu . The handbook is an important resource throughout your child's enrollment in our program. The parent handbook is also available in your child's classroom and if you would like a hard-copy please talk to the assistant director.

We look forward to getting to getting to know your family and working together.

Children's Center

1919 W. Taylor St. M/C 525
Chicago, IL 60612
uicchildcenter@uic.edu

CHILD INFORMATION FORM

As a parent/guardian you are our most important resource on your child. As such, we would like to learn more about your child and family. Please take a moment to complete the following questionnaire. Answer as many questions as you feel comfortable with. Please be assured your responses will be kept confidential. Your input will assist the teaching staff in meeting your child's individual needs and interests in his/her classroom. We appreciate your time and attention in responding to this valuable tool.

Child's Full Name (as it appears on her/his birth certificate) ____________________________________

Date of Birth:____________________ Place of Birth:___________________________

Name by which your child is usually addressed:_______________________________________

Name you would like your child to learn to write:_______________________________________

Name of Guardian I:____Relationship_________

Name of Guardian II:____ Relationship_________

Family Status: Married Single Divorced/Separated Widowed

List the family members your child lives with-include names, relationship, age(siblings):

In the event of a **non-emergency** what is the best method to communicate with you about your child? Please specify:

Email___________________ Phone____________________ Conference Written message

Will you require a translator in order to communicate with us about your child? YES NO

What is your family's cultural/ethnic heritage?____

Please share some of the traditions (cultural/household) that are important to your family:

YOUR CHILD'S LANGUAGE DEVELOPMENT

What is your child's primary spoken language?____

Is there another language your child is hearing or learning?__________________________________

Does your child understand English? YES NO

Describe your child's language and communication abilities:

___1 -2 word utterances ____simple sentences ____complex & elaborate sentences

Does your child use any special words or expressions which his/her teachers may not understand?

Describe any concerns you may have about your child's language development?

INFORMATION ON TOILETING

At what age was your child toilet trained?

Did you encounter any difficulties?

What terms does your child use at home for toileting?

Check the self-help skills that your child usually does without assistance:

____Pull pants/underwear up and down ____wiping independently ____washing hands

Describe any concerns you may have about your child's toilet habits:

YOUR CHILD'S HEALTH

Describe any allergies your child has and the reaction if he/she comes in contact with the allergen:

Are any medications given regularly? NO YES If yes, what?

Has your child had a serious illness or hospitalization? Please describe circumstances, such as his/her age, length of time, and the effect on him/her.

Please tell us about concerns you may have about your child's health:

YOUR CHILD'S EATING HABITS

My child: ____Likes most foods ____Is sometimes picky ____Has preferred foods

Check the self-help skills that your child usually does without assistance:

_____Feeds her/himself with utensils _____drinks out of a cup

My child's favorite foods are:____

My child dislikes these foods:____

Do you have any particular concerns about your child's eating habits or meal routines?

YOUR CHILD'S SLEEPING HABITS

My child has a regular bedtime schedule: YES NO

What time does your child usually go to sleep at night and wake up in the morning? ________________

My child naps at home: NO YES Sometimes for how long?_____________________

What are some ways you use to help your child transition to sleep?

Does your child have a favorite item to sleep with? NO YES Does the item have a special name?

Describe any concerns you may have about your child's sleeping habits:

YOUR CHILD'S SOCIAL/EMOTIONAL DEVELOPMENT

Describe your child's personality & temperament:

How does your child express anger or react to frustration?

Does your child have any particular fears? NO YES Please describe:

What methods of reassurance work best for your child?

Describe your child's…

- Preferred playmates

- Favorite interests/activities

Has your child ever been separated from you? NO YES Please describe (when, for how long, your child's overall reaction):

Describe how you think your child will adapt to group care:

FAMILY EXPECTATIONS

My expectations or goals for my child's experiences at the UIC Children's Center are:

GENERAL INFORMATION

Please describe any unique circumstances in your family or child's life that may affect your child's current behavior (new sibling, a recent move, death in the family, etc.):

Please give any information concerning your child that you feel will help us provide better care:

FAMILY INVOLVEMENT

I'm interested in participating in the program: Regularly Occasionally Once in a while

Do you have any skills, traditions, or talents that you would be willing to share?

PARENT SIGNITURE DATE

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EMERGENCY MEDICAL CARE

I authorize UIC Children's Center staff to secure EMERGENCY medical treatment for my child by contacting the UIC police and if necessary to transport my child to the UIC Medical Center for treatment.

I accept responsibility for maintaining health insurance coverage for my child. I accept responsibility for any reasonable expenses incurred in the medical treatment of my child which is not covered by the insurance policy listed below. I acknowledge that UIC Children's Center is not responsible for payment of any expenses incurred in the medical treatment of my child. I accept responsibility for updating UIC Children's Center staff of any changes to my child's insurance coverage and the insurance policy listed below.

_______________________________________ ______________________

CHILD'S NAME BIRTHDATE

____ ______________________

HEALTH INSURANCE COMPANY COVERING CHILD POLICY NUMBER

____ _______________________

NAME OF POLICY HOLDER RELATIONSHIP TO CHILD

____ ______________________

PARENT/GUARDIAN SIGNATURE DATE

____

PARENT/GUARDIAN CELL PHONE

REVISED/REVIEWED BY LEGAL 5.16

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CHILD RELEASE AUTHORIZATION

I authorize the following people to pick up my child from the UIC Children's Center. I understand that I must notify Center staff in advance when someone other than his/her parent/guardian will pick up my child. I understand that my child **WILL NOT** be released to any other persons than those listed below without my **WRITTEN** authorization, and that the authorized person must present a photo ID to a teacher or administrator prior to the release of my child. More information on the release of children can be found in the Center's Parent Handbook.

CHILD'S NAME____

NAME____RELATIONSHIP TO CHILD___________

ADDRESS_____________________________________CELL PHONE______________________

NAME____RELATIONSHIP TO CHILD___________

ADDRESS_____________________________________CELL PHONE______________________

NAME____RELATIONSHIP TO CHILD___________

ADDRESS_____________________________________CELL PHONE______________________

NAME____RELATIONSHIP TO CHILD___________

ADDRESS_____________________________________CELL PHONE______________________

____ **I DO NOT AUTHORIZE THE UIC CHILDREN'S CENTER STAFF TO RELEASE MY CHILD TO ANYONE OTHER THAN MY CHILD'S PARENTS/GUARDIAN.**

I UNDERSTAND THAT I MAY ADD OR REMOVE PERSONS FROM THE LIST AT ANY TIME.

Printed name of Parent/Guardian____

Parent/Guardian signature ____**Date**________

PLEASE CONTINUE ON BACK

EMERGENCY CONTACT INFORMATION

Please provide the following information so that we may contact you in the event of an emergency:

PARENT/GUARDIAN I **___FIRST CONTACT IN AN EMERGENCY**

NAME____

CELL PHONE NUMBER____

CAMPUS/WORK PHONE NUMBER____

ANY OTHER PHONE NUMBERS WHERE YOU MIGHT BE REACHED:

PARENT/GUARDIAN II **___FIRST CONTACT IN AN EMERGENCY**

NAME____

CELL PHONE NUMBER____

CAMPUS/WORK NUMBER____

ANY OTHER PHONE NUMBERS WHERE YOU MIGHT BE REACHED:

ADDITIONAL CONTACT

SHOULD THE UIC CHILDREN CENTER STAFF BE UNABLE TO REACH EITHER PARENT/GUARDIAN PLEASE CONTACT: (PLEASE LIST THIS PERSON ON THE RELEASE AUTHORIZATION LIST ON THE OTHER SIDE.)

NAME____________________________________RELATIONSHIP_______________________

CELL PHONE NUMBER____

CAMPUS/WORK NUMBER____

ANY OTHER PHONE NUMBERS WHERE YOU MIGHT BE REACHED:

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CONSENT FORM

Child's Name____

Date of Birth_______________________

Parent Handbook

I am aware that the UIC Children's Center Parent Handbook is available in booklet form or online at www.childrenscenter.uic.edu. The handbook includes pertinent information such as rules governing Center operations, guidance & discipline approaches, billing procedures, emergency medical procedures, food service, and more. I understand that I may request a hardcopy of the parent handbook at anytime. I have read and agree to abide by all of the policies and procedures as outlined in the handbook.

____
Parent/Guardian initials

Walking Fieldtrips

I authorize the UIC Children's Center to take my child on walking field trips as part of the early childhood education curriculum. Walking trips may include a variety of on-campus sites such as parent offices, student centers, or other appropriate locations. Off-campus walking field trips may include sites such as parks or other interesting locations. I understand that all trips are under the supervision and control of the UIC Children's Center staff and volunteers; and that health and safety precautions are taken in compliance with DCFS standards for licensure. I hereby release and covenant not to sue the Board of Trustees of the University of Illinois and any and all of its trustees, officers, employees, and representatives from any and all claims and causes of action for any injuries, disability, death, damages, loss or expenses arising out of, or in any way connected with my child's participation in such trips.

____
Parent/Guardian initials

Family Roster

As a way to support friendships outside of the Children's Center a yearly Family Roster is created and shared with families of the children participating in our program.

______I give permission to have my cell phone number and e-mail address on the roster.

Please do not include the following information on the family roster:
____ Cell phone number ____E-mail address
____ I do not want any of my information included _______________
Parent/Guardian initials

Photo/Video Consent

Throughout the year, the UIC Children's Center will occasionally photograph or videotape your child participating in Center activities. Photographs and videotapes are used in classrooms to document participation in learning experiences, preparation of child portfolios, observational processes, developmental assessment strategies, and similar purposes. Additionally, photographs may be printed or appear in promotional materials such as brochures, websites, or display boards. Photographs may also be shared in publications such as a Center newsletter and occasionally the UIC News. <u>Children's names will not be used publicly without additional specific written permission from the parents or legal guardian.</u>

Please <u>choose one</u>:

_____ I give permission for photographs and video of my child to be taken while he/she is involved in the programs of the UIC Children's Center. I understand that these photographs and videotapes may be used for any and all of the purposes described above, and that I will not receive compensation for the use of my child's photograph nor will I have ownership rights to the photographs/videos. _________ Parent/Guardian initials

_____ I give permission for photographs and video to be taken of my child for **internal use only**, to include display within the Center, individual child portfolios, and class portraits. Please note that your child's photo may be included in another child's portfolio to document group or peer activities. Please also note that your child's photo will not be included in any electronic communications from the Center such as class or Center-wide newsletters.
_______________ Parent/Guardian initials

_____ I **do not** give permission for ANY photographs or video of my child to be taken while he/she is involved in the programs of the Center. ___________Parent/Guardian initials

By initialing above, I agree to and or grant consent/permission as described above.

_________________________________ _________________________________
Printed name of Parent/Guardian **Parent/Guardian signature**

____
Date

Revised/reviewed by legal 5.16

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PARENT CONSENT FOR DEVELOPMENTAL SCREENINGS

Name of Child_______________________________________ Gender____________

Date of Birth___________________________________ Age_________________

Upon enrollment, and yearly thereafter, the UIC Children's Center assesses all children using the **Early Screening Inventory-Revised (ESI-R)** and the **Ages and Stages Questionnaire: Social–Emotional (ASQ:SE).** Information gained from both screening tools in conjunction with observations by classroom teachers and intake information shared by parents is used to identify a child who may benefit from a more extensive developmental assessment.

The **Early Screening Inventory-Revised (ESI-R)** is a brief developmental assessment performed one-on-one with your child by a member of the UIC Children's Center teaching staff. The assessment asks the child to do simple tasks like hopping on one foot, walking on a line, matching pictures, and responding to questions. These activities are not meant to measure intelligence. Rather, the screening will help the teachers know more about my child's growth and development. The results of the ESI-R will be shared with you during your first formal parent/teacher conference.

Families are asked to participate in the assessment process by completing the **Ages and Stages Questionnaire:Social–Emotional (ASQ:SE)**. The ASQ:SE will help us better recognize the milestones that your child has reached, as well as address any concerns you may be having. The results of the ASQ:SE will be shared with you during your first formal parent/teacher conference.

All children are assessed using the ESI-R and the ASQ:SE within 45 calendar days of entry into the program and again within 45 calendar days of the beginning of a new school year. All results are stored and shared in a confidential manner.

I have read and understand UIC Children's Center developmental screening policies and procedures. I grant permission for my child to receive the **Early Screening Inventory-Revised (ESI-R)** and I agree to complete the **Ages and Stages Questionnaire:Social–Emotional (ASQ:SE)** developmental screening and return the completed forms to the assistant director.

___________________________________ ______________________________________

Printed name of Parent/Guardian Parent/Guardian signature

____

Date

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DISCIPLINE POLICY

The purpose of all discipline at the Center is to help children develop self-control and to become responsible for their own behavior. We are committed to helping children become part of their group by learning to express feelings appropriately, to consider other people's feelings and to negotiate their own conflicts and differences.

We use non-punitive methods of discipline which are directly related to the child's behavior and encourage his/her participation. We ask the child to think about the problematic behavior and to find ways to remedy the situation. This approach depends upon cooperation and negotiation and requires the adult to maintain a non-punitive attitude.

The following actions are strictly prohibited at the Children's Center:

- Corporal punishment, including hitting, spanking, swatting, beating, shaking, pinching, and other measures intended to induce physical pain or fear
- Threatened or actual withdrawal of food, rest or use of the bathroom
- Abuse and profane language
- Any form of public or private humiliation, including threats of physical punishment
- Any form of emotional abuse including shaming, rejecting, terrorizing or isolating a child

--*Section 407.270 IL. Dept. of Children and Family Services Licensing Standards for Day Care Centers*

Teachers observe all children and document any problem behavior to help ascertain any patterns or precipitating factors. Teachers will communicate behavior concerns to parents as soon as they are observed, as well as the actions taken to rectify the situation.

Should a child exhibit disruptive and unsafe behavior on a continual basis that is not resolved through appropriate behavior management strategies, teachers will discuss the situation with a supervisor and parents to develop a plan of action. If the behavior problem is still not resolved, Center staff will request a meeting with the child's parent(s) to collaborate and develop a team approach in working with the child. Staff will keep parent(s) informed of progress in resolving the problem. If staff members feel that additional assistance is needed, they may **with parental permission** consult community resource persons and/or refer the child for an evaluation. If the results of an outside evaluation suggest the need for accommodations for special needs, the program will provide these or other appropriate accommodations as long as they do not place undue hardship on the program as outlined in the Americans with Disabilities Act (ADA).

All reasonable attempts will be made to work with the child and the family to resolve the behavior problem. If parent(s) refuse to work with the staff in resolving the problem and/or the child's placement in the classroom compromises the health, safety and/or well-being of other children or staff members, enrollment will be terminated. In this case, parent(s) will be given two weeks written notice of withdrawal except where such notice is not reasonable because of safety concerns. Staff will try to assist the parent(s) in selecting an alternate program. Written documentation of all of the above steps will be provided to the parent(s) upon request and placed in the child's file.

I have read and understand the discipline policy maintained at UIC Children's Center and agree to follow it.

____ ____________

Parent(s) Signature Date

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			Code:
Age/ Grade																			P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail
Vision																			U = Unable to test R = Referred
Hearing																			G/C = Glasses/Contacts

Student's Name Last / First / Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level/ ID #**

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _______________
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _______________

LAB TESTS (**Recommended**)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

NAME:________________________ **D.O.B:**____/____/____

TEACHER:________________________ **GRADE:**____________

ALLERGY TO:____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Weight: ______ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

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)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin Monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): ________________________

ANTIHISTAMINE (BRAND AND DOSE): ________________________

Other (e.g., inhaler-bronchodilator if asthma): ________________________

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (____)________________

Parent/Guardian: ________________________ Ph: (____)________________

Name/Relationship: ________________________ Ph: (____)________________

Name/Relationship: ________________________ Ph: (____)________________

Licensed Healthcare Provider Signature:________________ Phone:____________ Date:____________
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature:________________________________ Date:____________

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name:____ Room:________________________

Name:____ Room:________________________

Name:____ Room:________________________

LOCATION OF MEDICATION

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: ____________________________

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)
414.272.6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital
800.543.7362 (800.KIDS DOC®)
http://www.childrensmemorial.org

Food Allergy Initiative (FAI)
212.207.1974
http://www.faiusa.org

Food Allergy and Anaphylaxis Network (FAAN)
800.929.4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.