CHEYENNE HILLS

PRESCHOOL

Registration Packet

7505 U.S. Hwy 30
Cheyenne, WY 82009

Stephanie Snow – Administrator
ssnow@cheyennehills.org

307-514-2109

Student's Name: ____

Age: ____________, D.O.B. ____/____/______

Please submit completed registration packet along with the application fee, a copy of child's birth certificate and current immunization records.
A separate packet must be filled out for each child.

Office Use Only	
Date Rec'd	____________________
Materials Fee	____________________
Registration Fee	____________________
Reg. Agreement	____________________
Acceptance Date	____________________
Notification Sent	____________________
Rec'd Handbook	____________________
Immunizations	____________________
Birth Certificate	____________________
Allergy/Med Plan	____________________

Notes:

____

____

____

____

____

Office Use Only

Dear Parents,

Welcome to Cheyenne Hills Preschool (CHP). We are delighted that you are interested in your child being apart of our preschool family! Over the years we have had many parents ask if we have thought of offering a preschool for the Cheyenne community. The truth is we have, but the timing was never quite right. We feel God's timing is now and we cannot be more excited! We have done all the preliminary footwork for state licensing and we are on track to be licensed by the start of the school year, September 1, 2018.

Our classes will provide each child with the same excellence as our weekend Sunday school classes. We will provide a safe and loving environment where children will learn and grow spiritually, academically and socially. Each day will be filled with fun and exciting adventures to help your child develop a love for God, a desire to learn and the skills to get along with others. Each class will be learning and exploring many concepts and themes throughout the school year.

We are so excited to begin this journey with you and look forward to getting to know each child as we learn and grow together.

Enclosed is the registration packet for enrollment into our program. Please fill out all documents completely that apply to your child. All students are required to have a **completed application, immunization records, a copy of their birth certificate and the non-refundable registration fee** to enroll.

Stephanie Snow
CHP Administrator
ssnow@cheyennehills.org

"Our Promise To You"
We promise you every day your
Child will learn something.
Some days they will bring it
home in their hands.
Some days they will bring it
home in their heads,
And some days they will bring it
home in their hearts.

Classes/Tuition:

CHP offers morning classes (MWF 9:00 a.m. - 11:30 a.m.) for students age three and four years and afternoon classes (M-F 1:00 p.m. – 3:30 p.m.) for students ages four and five years. Students must have turned the appropriate age required, for each class, by September 1st in order to be accepted into that class. Only those students who are at least 4 years and 6 months old may enroll in the afternoon PreK-4 class. Exceptions may be made at the discretion of the director.

Class	Age	Days of Week	Time	Tuition
PreK-4	4 years by Sept. 1st	MWF	9:00 a.m. – 11:30 a.m.	$190.00 per month
PreK-4	4 years by March 1st	M-F	1:00 p.m. – 3:30 p.m.	$295.00 per month
PreK-5	5 years by Sept 1st	M-F	1:00 p.m. – 3:30 p.m.	$295.00 per month

Additional Fees:

Additional fees include a one time $50.00 materials fee and a non-refundable registration fee of $85.00. The registration fee is due upon receipt of application and will reserve a spot for your child in our program. The materials fee is due by September 3, 2018.

Cheyenne Hills Church members will receive a 10% discount on their monthly tuition. Families with more than one child enrolled at CHP will receive a 10% discount on additional child(ren)'s tuition. Members enrolling their children in Cheyenne Preschool are required to serve during one of the Sunday services, at least once per month, in Children's Ministry at Cheyenne Hills Church to receive the member discount. Additional paperwork is required to serve in Children's Ministry.

Monthly tuition is due on or before the 5th of each month. A $30.00 late fee will be assessed to accounts which payments are received on or after the 6th of each month. Tuition not paid by the 10th of each month may result in student being dismissed from program until account is made current. If your payment has not been received by the end of the month, your child will be suspended until payment arrangements have been made.

School Year:

CHP 's school year, for the most part, coincides with Laramie County District #1's calendar (September-May). See CHP 2018-2019 School Calendar on the following page.

2018-2019 School Calendar

September

S	M	T	W	T	F	S
						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						

October

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	2
21	22	23	24	25	26	27
28	29	30	31			

November

S	M	T	W	T	F	S
				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	

December

S	M	T	W	T	F	S
						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					

January

S	M	T	W	T	F	S
		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		

February

S	M	T	W	T	F	S
					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		

March

S	M	T	W	T	F	S
					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						

April

S	M	T	W	T	F	S
	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				

May

S	M	T	W	T	F	S
			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	

School Closed/ Holidays

Parent/Teacher Conferences

First and Last Day of School

Planning/Staff Development Days

September
3 • Labor Day
4 • 1st day (morning classes)
5 • 1st day (afternoon classes)

October
30/31 • Parent/Teacher Conferences

November
19-23 • Thanksgiving Break

December
20 – Jan 1
• Christmas Break

January
2 • Classes Resume
21 • MLK Day

February
18 • Presidents' Day

March

April
1-5 • Spring Break

May
2-3 • Parent/Teacher Conferences
24 • Last Day of School

Medication

Medication will NOT be administered during the preschool program with the exceptions for treatment of asthma and/or allergic reactions. In order for our staff to administer medications for the aforementioned conditions the following MUST be adhered to:

1. A medication waiver and consent form must be completed and signed by a parent/guardian AND the prescribing physician.
2. A Food Allergy Action Plan (if applicable) must be on file in your child's record.
3. An Asthma Action Plan (if applicable) must be on file in your child's record.
4. All medications must be in original container, and must be clearly labeled with child's name.

Immunizations:

In compliance with the State of Wyoming all students attending CHP are required to have current immunizations in order to be accepted to our program. Immunization records must accompany each application upon registration. The following are acceptable documents that will be accepted as evidence of a pupil's immunization history.

1. An immunization record from any local or state Public Health Department or unit indicating compliance with W.S. § 35-1-240(a)(ii), W.S. § 35-4-101, W.S. § 21-4-309, and W.S. § 14-4-116, and the Wyoming Administrative Procedure Act of W.S. § 16-3-101, et seq.

2. A certificate signed by a physician licensed to practice medicine in any jurisdiction of the USA indicating compliance with W.S. § 35-1-240(a)(ii), W.S. § 35-4-101, W.S. § 21-4-309, and W.S. § 14-4-116, and the Wyoming Administrative Procedure Act of W.S. § 16-3-101, *et seq.*

3. An Official State Record of Immunization report generated from the Wyoming Immunization Registry.

4. A report from a certified laboratory or acknowledgement from a pupil's healthcare provider that confirms serologic immunity to measles, mumps, rubella, hepatitis A, hepatitis B, or varicella.

Cheyenne Hills Preschool Application For Enrollment 2018-2019

In order to understand and best meet the needs of the children attending Cheyenne Hills Preschool, we ask parents/guardians to complete this form. The information you provide is strictly confidential and will only be shared with Cheyenne Hills Preschool staff. Thank you for the time and thought that this form requires.

Student's Name: ______________________________ D.O.B.____/____/____ Gender: □ M □ F

Primary home number (for class list): ______________________________ Todays date: ______________

Address: ____

Morning Class: □ PreK-3 (9 a.m.–11:30 a.m. MWF) □ PreK-4 (9 a.m.–11:30 a.m. MWF)

Afternoon Class: □ PreK-4 (1:00 p.m.-3:30 p.m. M-F) □ PreK-5 (1:00 p.m.-3:30 p.m. M-F)

Parent/Guardian Information: (Please complete for both parents/guardians, if appropriate)

Parent/guardian name: ____

Address: ____

Date of birth: ______________________ Occupation: ______________________________

Employer's Name: ______________________ Work phone: (_____)______________________

Parent/guardian name: ____

Address: ____

Date of birth: ______________________ Occupation: ______________________________

Employer's Name: ______________________ Work phone: (_____)______________________

Parent/Guardian Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Who has custodial rights: □ Father □ Mother □ Guardian

SIBLINGS:	**Name**	**Date of Birth**	**Age/Grade**

Emergency Contact and/or Authorized Person (s) Form

Student's Name: ______________________________ Date: ______________________________

Emergency Contact = (EC)
In the case of an emergency where parent/guardian(s) cannot be reached the following individuals may be contacted and are authorized to take the above named student from the CHP facility.

Authorized person (s) = (AP)
In the case where parent/guardian(s) are unable to pick up child from CHP, the following individuals are authorized to take the above named student from the CHP facility.

Name: ______________________ ☐ EC ☐ AP ☐ Both Cell#______________ Addl. #______________

Address: ____

Name: ______________________ ☐ EC ☐ AP ☐ Both Cell#______________ Addl. #______________

Address: ____

Name: ______________________ ☐ EC ☐ AP ☐ Both Cell#______________ Addl. #______________

Address: ____

Name: ______________________ ☐ EC ☐ AP ☐ Both Cell#______________ Addl. #______________

Address: ____

NOTE: students will only be released to those person authorized to pickup them up. A driver's license is required, each time, to verify identification of person picking up students.

Parent Agreement: (Initial each box indicating agreement)

________ Attendance **Requirements:** an authorized adult must sign students, attending CHP, in and out through the kid-check kiosk. Absences must be reported to the preschool office. **Only** authorized adults will be able to drop-off and pickup students.

________ **Program Charges:** An annual non- refundable fee of $85.00 is due at the time of registration. Tuition is expected to be paid on or before the 5th of each month. If payments are not received by the 5th of each month, I understand I will be charged a $30.00 late fee. Failure to pay by the 10th of each month may result in dismissal from program until account is made current. A late pick up fee of $2.00 per minute will be charged after 11:35 a.m. for morning classes and after 3:35 p.m. for afternoon classes. Excessive late pick-ups may result in the student being excluded from the preschool program. Any students not picked up by noon for morning classes or 4:00 p.m. for afternoon classes (after attempts to contact all emergency contacts) may result in the Sheriff's department being called to pick up said student. A $35.00 fee will be charged on all returned checks, and may result in a cash or money order only restriction being put on the account. Repeated late tuition payments or returned checks may result in exclusion from the preschool program until the account is brought current.

________ I understand that participation in the preschool program will include outdoor activities and all the risks that accompany such activities. In case of an emergency, staff will first contact parent/guardian. If an attempt to contact a parent/guardian is not successful an authorized emergency contact will be contacted. If immediate hospital attention is needed, staff will call 911 and accompany student if necessary. I understand that I will be held responsible for all costs incurred. I therefore waive any claims and agree to release and hold harmless Cheyenne Hills Preschool and/or Cheyenne Hills Church.
I have read, understand and agree to abide by all of the above statements:

Parent/Guardian Signature: ______________________________ Date: ____________________

FAMILY AND DEVELOPMENT HISTORY

Please answer the following questions, sharing as much information as you feel comfortable. This information helps us to understand and validate each child's experience. Cheyenne Hills Preschool respects the diverse composition of its families and is committed to protecting each family's right to privacy. Whatever you share with us here is confidential and will not be shared with others.

What languages are spoken at home? ______________________________

If parents are divorced or separated, please indicate when this took place: ______________________________

♦ If parents share custody, what are the living arrangements for the child?

____

♦ If parents do not share custody:

Who is the custodial parent? ______________________________

Name/Address of non-custodial parent: ______________________________

____

How much time does the child spend with the non-custodial parent? ______________________________

Who cares for your child when parents/guardians are not home? ______________________________

How many hours/week? ______________

How long has this person cared for the child? ______________________________

Has there been any change in the person or arrangement in the past year? ________ If yes, please describe:

____

Does your child receive support services/therapies in any area of development or have any special needs that have been identified (i.e.: speech and/or language delays; physical disabilities; developmental delays; motor or sensory integration issues; social/emotional/behavioral difficulties)? If yes, please describe briefly:

____

____

____

Does your child have a sibling with an identified special need? If yes, briefly explain:

____

____

____

Are there any areas of your child's development that you are concerned about and would like us to observe (e.g.: speech/language development; fine and gross motor skills; learning skills; social/emotional/behavioral skills)? If yes, please explain briefly:

____

____

____

Please share any other family situations that would be helpful for your child's teacher to know:
(e.g.: adoption of child/sibling, separation/divorce, blended family, recent/pending move, recent death/loss, foster care arrangements, etc.)

____

____

____

MEDICAL HISTORY

Was your child a full-term baby? ____________ If not, how many weeks? ____________________________

Please describe any special factors concerning pregnancy or delivery. (Answer in terms of biological/birth parent if your child joined your family through adoption or is in your foster care.)

____

____

Please describe any special circumstances in your child's early development (e.g.: extensive hospitalization, prolonged separation from primary caregiver, change of custody).

____

____

Is your child subject to colds? _________ Ear infections? ________ Strep? _________ Sinus Infections? ________ Bronchitis? ________

If yes, how often? ____

Does your child have non food-based allergies (e.g. hay fever, pet dander, dust, mold, etc.)? ______________

If yes, please explain: ____

Does your child Have drug allergies? ___________

If yes, please explain: ____

If you answer "yes" to any of the following questions, you will need to fill additional forms located at the end of this packet. Forms MUST be completed and signed by YOU & YOUR CHILD'S PHYSICIAN and returned by august 15.

Does your child have asthma? ___________, if yes list triggers/symptoms: ____

Has your physician prescribed an inhaler ________________ If yes, list name of inhaler: ________________ If yes, the Asthma Action Plan

Form and the Medication Waiver and Consent Form **MUST** be fill out.

Does your child have food allergies that require a special diet? _____________, if yes please specify: ______________________________

Type of reaction: ____

Is an Epi-pen required/prescribed by a physician? ______________ If yes, the Food Allergy Action Plan Form and the Medication Waiver

and Consent Form **MUST** be filled out. **Parent is responsible for providing the EPI-pen**.

Does your child have a serious medical condition that may require monitoring or special treatment at school (e.g. diabetes, cystic fibrosis, seizure disorder, cancer)? ___________________, if yes additional documentation may be required.

Has your child had any serious illnesses, operations, accidents, or hospital stays? ______________

If yes, please explain: ____

____

Are there any health factors that you would like us to observe?

____

Please share any other health factors which would be helpful for your child's teacher to know:

____

BEHAVIOR AND DISCIPLINE

What do you see as your child's strengths?____

____

What does your child like to do most? ____

Please share anything about your child's behavior that may be difficult for you or others to manage.

____

____

Has your child exhibited difficulty separating from you? Adapting to new situations? Do you anticipate your child will have separation issues at the beginning of the school year?

____

____

____

Please share any specific situations in which your child becomes tense, afraid, or angry.

____

____

In general, how do you limit or discipline your child?

____

____

____

Describe how you see your child in terms of independence or wanting/needing help with things such as dressing, washing, toileting, problem solving.

____

____

____

ADDITIONAL INFORMATION

• **TOILET TRAINING**:

Is your child toilet trained except for occasional accidents? _______________

What words does your child use when he/she needs to use the bathroom? ______________________________

Is there anything about your child's toileting habits, which the teachers should know?

____

____

• **SLEEPING:**

Does your child take a nap? _______________ What hours? ______________________________

What is your child's usual bedtime? ______________________ What time does your child awaken? ______________________

Does your child go to sleep easily? ______________________ Sleep through the night? ______________________

If not, please explain: ____

____

• **GROUP EXPERIENCES:**

Is your child enrolled/participating in another preschool/daycare program? ____________________

Name/address of program or day care home____

Days/hours of attendance ____

Please share any previous experience(s) your child has had in playgroups, preschool, day care, camp, Sunday school:

Group experience	**Where**	**When**

Was a parent/guardian included in any of these experiences? _______________

If yes, please explain: ____

What do you hope your child will gain from this coming year at Cheyenne Hills Preschool? Please share your goals for your child:

____

____

____

Who will be bringing your child to school most of the time? ____

• **HOW DID YOU LEARN ABOUT CHEYENNE HILLS PRESCHOOL?** ____

____

Is there any other information that you would like to share about your child?

____

____

____

____

Parent/guardian Name (Please Print)

____ ________/________/__________

Signature of parent/guardian completing this form Date

EMERGENCY MEDICAL CONSENT FORM

Cheyenne Hills Preschool/Cheyenne Hills Church has my permission to administer first aide and/or obtain emergency medical treatment for my child, ____(Full legal name) when I cannot be reached and/or when immediate medical attention is required for him/her.

Child's Information

Child's Full Name: ____ Address: ____

Date of Birth: ______________________ Age: _______________________

Parent/Guardian's Information

Parent's/Guardian's Name 1: _____________________________ Address: ____

Phone Number (H): _________________________ Phone Number (C): ___________________________

Parent's/Guardian's Name 2: _____________________________ Address: ____

Phone Number (H): _________________________ Phone Number (C): ___________________________

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes): ____

Allergies (e.g. to Medications, Food): ____

Prescription Medications: ____

Date of Last Tetanus Injection/Booster: __________________________________

Child's Medical Care and Insurance Information

Physician/Pediatrician: ______________________________________ Phone Number: __________________________

Dentist/Orthodontist: ____ Phone Number: __________________________

Insurance Company: ____

Policy/Group Number: _______________________________ Policy Holder: ________________________________

SIGNATURE OF PARENT/GUARDIAN

Signature ____ Date ________________________

Print Name ____

General Photo Release Form

I hereby grant Cheyenne Hills Preschool permission to take and use my child's photograph in connection with school activities and projects, for use in school displays, portfolios, publications and web site posts related to the preschool, without payment or any other consideration in perpetuity. These photographs are used for internal communication and projects, promoting the preschool and as shared content amongst preschool families.

I have read and understand the above. Please make your selection below:

☐ I **DO** grant permission for my child to be photographed

☐ I DO **NOT** grant permission for child to be photographed

Signature ____

Printed Name ____

Child's Name ________________________________ Date ________________

Cheyenne Hills Preschool

Medication Waiver & Consent Form

ONE FORM PER MEDICATION MUST BE FILLED OUT COMPLETELY BY A PARENT/GUARDIAN AND THE STUDENT'S PRESCRIBING PHYSICIAN.

Student's Name: ______________________ Medication: ______________________

Dates for Administration: From ______________ To ______________
(Date) (Date)

☐ Prescription ☐ Non-Prescription Refrigerate: ☐ Yes ☐ No

Dosage: ____________ Time to Administer: ________ a.m. ________ p.m. ________times/day

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication:

____

____

Possible side effects: ____

Actions to be taken if above side effects occur: ______________________________

Prescriber's Name:______________________ Phone # ______________________
(Please Print)

Physician Signature: ______________________ Date: _____/_____/_______

All medications whether prescription or over the counter must be in it's original labeled container. Non-prescription medicines must be clearly labeled with student's first and last name. Medications must be current and replaced by the expiration date in order to be administered/distributed by CHP staff member.

The undersigned hereby acknowledges and represents that he/she is the parent/legal guardian or person legally responsible for the above named child while he/she is under the supervision of the programs sponsored and operated by Cheyenne Hills Preschool.

The undersigned further acknowledges that he/she has requested and consents to Cheyenne Hills Preschool staff, it's employees and/or duly authorized agents, to administer or assist in administering the above-indicated medication while the above named child is under the supervision of Cheyenne Hills Preschool.

Now, in consideration of the administering or assistance in administering said medication, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify Cheyenne Hills Preschool and/or Cheyenne Hills Church, its employees and duly authorized agents of and from any and all claims, demands, suits, actions, and liabilities or responsibilities of whatsoever kind or nature, arising out of or in connection with administering or assistance in administering of said medication.

Parent/Guardian Name: ______________________________________
(Please Print)

Parent Signature: ______________________ Date: _____/_____/_______

DAILY MEDICATION RECORD
For Staff Use Only

Child's NAME ______________________________ Administering Staff Name: ______________________________

MEDICATION AND DOSAGE: ____

TIME(S) MEDICATION TO BE GIVEN: ____

DATE	TIME	GIVEN BY	Leaders Initials

SNACK FORM
Please fill out only if your child has food allergies

I agree to the following:

☐I will not be checking snacks, as my child can eat all of the snacks served at CHP. **All snacks at CHP are nut free.**

☐I **will** be checking the snack menu and will indicate what foods my child can't have on the snack menu. **Those items will not be served in the classroom.**

☐ **My child is not allergic but just sensitive to certain foods, so I will be checking the snack menu and indicating what foods my child can't have. Those items will be served in the classroom, but not served to my child.**

☐My child can drink milk.

☐My child can eat legumes, as well as other foods in the legume family, e.g., beans, peas, lentils, soybeans, etc.

Child's Name: ____

Parent's Name: ____

Parent's Signature:_____________________________ Date: _____/_____/_______

Child's Name: ____

Parent's Name: ____

Taking my child's allergies into account, I give him/her permission to touch and use the following items at school:

☐ Playdough (may contain wheat, corn)

☐ Pasta (may contain wheat, eggs) ___Beans /Legumes

☐ Rice/Other Grains

☐ Tempera Paint

☐ Fingerpaint

☐ Crayons

☐ Shaving Cream

☐ Goop/Slime (may contain corn)

☐ Paper Mache

☐ Liquid Soaps

If there are any other concerns or issues that we should be aware of that my child should not come into contact with, I agree to let you know.

Signature: ______________________________________ Date: ______/______/__________

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

PLACE PICTURE HERE

Name: ____________________ D.O.B.: __________

Allergy to: ____________________

Weight: __________ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: ____________________

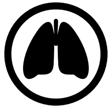
THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

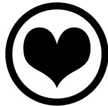
[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

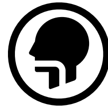
SEVERE SYMPTOMS



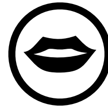
LUNG
Short of breath, wheezing, repetitive cough



HEART
Pale, blue, faint, weak pulse, dizzy

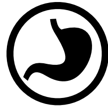


THROAT
Tight, hoarse, trouble breathing/ swallowing

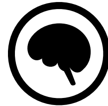


MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting, severe diarrhea



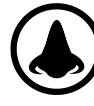
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

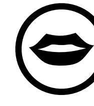
1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy/runny nose, sneezing



MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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: ____________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ____________________

Antihistamine Dose: ____________________

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

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

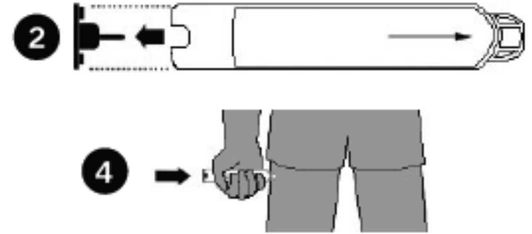
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

FARE — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Food Allergy Research & Education

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: ____________

PARENT/GUARDIAN: ____________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

Asthma Action Plan

For: ____________________ Doctor: ____________________ Date: __________

Doctor's Phone Number____________________ Hospital/Emergency Department Phone Number ____________________

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

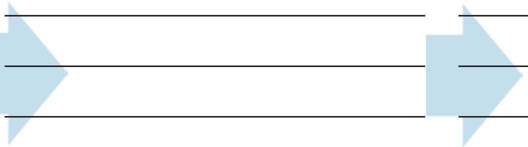
And, if a peak flow meter is used,

Peak flow: more than __________
(80 percent or more of my best peak flow)

My best peak flow is: __________

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it



Before exercise	❒ __________	❒ 2 or ❒ 4 puffs __________	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: ________ to ________
(50 to 79 percent of my best peak flow)

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

____________________ ❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour
(short-acting $beta_2$-agonist) ❒ Nebulizer, once

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:

❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

❒ Take: ____________________ ❒ 2 or ❒ 4 puffs or ❒ Nebulizer
(short-acting $beta_2$-agonist)

❒ Add: ____________________ mg per day For __________(3–10) days
(oral steroid)

❒ Call the doctor ❒ before/ ❒ within ________ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than __________
(50 percent of my best peak flow)

Take this medicine:

❒ ____________________ ❒ 4 or ❒ 6 puffs or ❒ Nebulizer
(short-acting $beta_2$-agonist)

❒ ____________________ mg
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance** __________ **NOW!**
(phone)

See the reverse side for things you can do to avoid your asthma triggers.

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

❒ **Animal Dander**

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

❒ **Dust Mites**

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

❒ **Cockroaches**

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

❒ **Indoor Mold**

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

❒ **Pollen and Outdoor Mold**

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

❒ **Tobacco Smoke**

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

❒ **Smoke, Strong Odors, and Sprays**

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

❒ **Vacuum Cleaning**

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

❒ **Other Things That Can Make Asthma Worse**

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

For More Information, go to: www.nhlbi.nih.gov

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