



Medicine Authorization Form

*** Must provide a copy of current doctor's immunization records**

Child's Name: _____ DOB: ____/____/____ Age: _____

Name of Parent or Legal Guardian: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Email: _____

Medical Summary

List any diagnosis or health concern (asthma, diabetes, chronic illness, seizures, etc.): _____

If your child does suffer from asthma, diabetes or other any chronic illness, you will be required to fill out a Medical Action Plan.

Has the child ever had a severe reaction to anything (penicillin, bee stings, etc.)?

Please list all of the child's severe food allergies: _____

If, yes, please explain including whether the child needs an Epi-pen at school.

List any current or prescribed medications and dosages:

List any past hospitalizations, surgeries or injuries (ear infections, placement of tubes, tonsillectomies, etc.): _____

Please list any family medical history that might be important for the school to know: _____

List any speech/ language or motor development concerns that you or the parents have: _____

Other Comments: _____

Parent Signature: _____ Date: ____/____/____



Medicine Authorization (Continued)

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Medical Summary (to be filled out by your pediatrician)

Please check if abnormal and comment:

Form with checkboxes and lines for medical summary: Skin, Mouth & Dental, Eyes, Ears, Lymphatic, Orthopedic, Genitalia Hernia, Abdomen, Chest, Heart.

Significant findings and physician's recommendations to parents and teachers:

Three horizontal lines for significant findings and physician's recommendations.

Other Comments: followed by three horizontal lines.

Recommendations for Physical Education: Full Program Restricted
If marked Restricted, please explain:

Horizontal line for explanation of restricted recommendations.

Doctor's Signature: M.D. Date: / /

Please mail in completed Medical Authorization and Current Immunization Records to:

Bambini Creativi
400 East 135th Street
Kansas City, MO 64145
Email to: brianne@bambinicreativi.com
Phone: (816) 941. 7529 or (PLAY)

Asthma & Allergy Action Plan

Name: _____ D.O.B.: _____
 Allergy to: _____
 Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No








PROGRAM SCHEDULE:

For a suspected or active food allergy reaction:

M T W TH F HALF OR FULL

FOR ANY OF THE FOLLOWING
SEVERE SYMPTOMS

If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	OR A COMBINATION of mild or severe symptoms from different body areas.

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

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

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

 NOSE Itchy/runny nose, sneezing	 MOUTH Itchy mouth
 SKIN A few hives, mild itch	 GUT Mild nausea/d discomfort

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1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.
 - Consider giving additional medications (following or with the epinephrine):
 - × Antihistamine
 - × Inhaler (bronchodilator) if asthma
 - Lay the student flat and raise legs. 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 first dose.
 - Alert emergency contacts.
 - Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

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 asthmatic): _____

EMERGENCY CONTACT #1 NAME: _____ RELATIONSHIP: _____ PHONE: _____

EMERGENCY CONTACT #2 NAME: _____ RELATIONSHIP: _____ PHONE: _____

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