medical authorization

BAMBINICREATIVI

2024-2025

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:_____/_____/_____

medical 2 authorization

BAMBINICREATIVI

2024-2025

Medicine Authorization (Continued)

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

Medical Summary (to be filled out by your pediatrician)

Please check if abnormal and comment:

____ Skin:_____ | _____ Mouth & Dental:_____

____ Eyes:_____ | _____ Ears:_____

____ Lymphatic:_____ | _____ Orthopedic:_____

____ Genitalia Hernia:_____ | _____ Abdomen:_____

____ Chest:_____ | _____ Heart:_____

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

_____

_____

_____

Other Comments:_____

_____

_____

Recommendations for Physical Education:_____ Full Program _____Restricted

If marked *Restricted,* please explain:_____

_____

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: brianneb@bambinicreativi.com

Phone: (816) 941. 7529 or (PLAY)

asthma & allergy action plan

BAMBINICREATIVI

2024-2025

Asthma & Allergy Action Plan

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs.

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

PROGRAM SCHEDULE:

M T W TH F HALF OR FULL

For a suspected or active food allergy reaction:

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.**

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 last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

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/discomfort

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.**

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

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