1 medical authorization

BAMBINICREATIVI

2022-2023

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:____

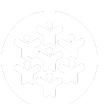
List any speech/ language or motor development concerns that you or the parents have:____

Other Comments:____

____

____

Parent Signature:____________________________ Date:_____/_____/______



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2 medical authorization

BAMBINICREATIVI

2022-2023

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: brianne@bambinicreativi.com

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

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asthma & allergy action plan

BAMBINICREATIVI

2022-2023

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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