

Asthma Information Sheet and Checklist

We ask the parents/guardians submit a completed Asthma Action Plan and any other required forms at least 7 days before the participant's first day of program. This allows staff time to make accommodations and train appropriate personnel.

Parent/Guardian Checklist:

Before the participant's first day of attendance, the parent/guardian/designee is responsible for training selected members of the Park District staff, including but not limited to, the Program Manager, and the program staff on the following:

- ☐ Provide the Program Manager with written medical documentation, instructions, and medications as directed by a physician, using the Asthma Action Plan (attached).
- ☐ Complete Inhaler waiver.
- ☐ Provide properly labeled medications and replace medications after use or upon expiration.
- ☐ Prescription medications are reviewed and updated regularly by a physician.

All Park District staff that may have contact with the participant will be trained to know:

- Events/substances that may trigger asthma
- Limitations on the participant that may help prevent an asthma episode
- Symptoms of an asthma episode.
- When and how to administer treatment for an asthma episode.

Parent/Guardian's Signature: _____ **Date:** _____

Dispensing Medication Authorization

This form must be completed for each program session, for each medication, and/or when medication changes.

Program Name: _____ Date Completed: _____

PARTICIPANT INFORMATION

Participant's Name: _____ Age: _____

Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Cell Phone: _____

MEDICATION INFORMATION

Medication Name: _____ Prescription #: _____

Dosage Instructions: _____

Frequency Medication Must Be Administered: _____

Time Medication Must Be Administered: _____

Possible Side Effects: _____

Dispensing and Storage Instructions: _____

Does the child have any limitations which will occur due to the listed medication? ☐ Yes ☐ No

Other Information: _____

I understand that it is my responsibility to give the medication directly to program manager with full instruction in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

I authorize Glencoe Park District to administer specific medication listed above.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

Parent/Guardian Signature: _____ Date: _____



Asthma Action Plan

PLACE
PICTURE
HERE

PROGRAM NAME: _____ DATE COMPLETED: _____

PARTICIPANT NAME: _____ WEIGHT: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ PEAK FLOW: _____

SYMPTOM TRIGGERS: _____

Asthma Severity

Green Zone "Go! All Clear!"  - Breathing is easy - Can play, work and sleep without asthma symptoms Peak Flow Range (80% - 100% of personal best)	The GREEN ZONE means take the following medicine(s) every day: Controller Medicine(s) _____ Dose: _____ Spacer Used: _____ Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity: _____
Yellow Zone "Caution..."  - Breathing is easy - Cough or wheeze - Chest is tight Peak Flow Range (50% - 80% of personal best)	The YELLOW ZONE means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse. Reliever Medicine(s): _____ Dose: _____ If beginning cold symptoms, call your doctor before starting oral steroids. Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.
Red Zone "STOP! Medical Alert!"  - Medicine is not helping - Nose opens wide to breathe - Breathing is hard and fast - Trouble Walking - Trouble Talking - Ribs show Peak Flow Range (Below 50% of personal best)	The RED ZONE means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to the hospital emergency department or call 911 immediately. Reliever Medicine(s): _____ Dose: _____

Waiver and Release of All Claims for Use of Inhaler or Auto-Injector

Waiver and Release of all Claims and Indemnification

(Preschool)

Please read this form carefully and be aware that pursuant to the Illinois Asthma Inhalers at Recreational Camps Act, 410 ILCS 607/1 et seq., you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain in connection with the use of medication, including, but not limited to the use of an epinephrine auto injector or inhaler at the program or at any program-sponsored activity, event, or program; except for claims arising out of the willful and wanton conduct of the Glencoe Park District.

As parent/guardian of the below identified participant, I have informed the Glencoe Park District of the possible need for my child/ward to receive medication through an inhaler or auto-injector and I have informed the Glencoe Park District that my child/ward is not capable of self-administration of the medication. I recognize and acknowledge that there are certain risks of physical injury due to the administration or use of medication through an inhaler or auto-injector, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of the delivery of medication to my child. I further acknowledge that such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my

child/ward) against the Glencoe Park District -- including its officials, agents, volunteers and employees -- as a result of or arising out of the administration or delivery of medication to my child (except for claims arising out of the willful and wanton conduct of the Glencoe Park District).

I further agree to protect, indemnify, save, defend and hold harmless the Glencoe Park District from and against any and all liabilities, obligations, claims, damages, penalties, causes of action, costs and expenses (including reasonable attorney fees) for which the Glencoe Park District may become obligated by reason of the administration or use of medication except to the extent caused by the willful and wanton conduct of the Glencoe Park District.

I have read and fully understand the above waiver and release of all claims and indemnification. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Participant's Name (please print): _____

Parent /Guardian's Signature: _____

Date: _____

Authorization to Post Allergy Information

I hereby give authorization to the Glencoe Park District to post information in my child's classroom(s) pertaining to my child's allergy, including a photo, the nature of the allergy, and the emergency medical plan.

Parent /Guardian's Signature: _____

Date: _____