VBS Asthma Record

Child's Name:_____ Date of Birth:_____Grade:_____
Parents Name:_____ Phone (home):_____
Address:_____ Phone (work):_____
MD treating Child's Asthma:_____ Phone:_____

1. Describe what causes or precipitates your child's asthma symptoms (e.g., specific type of activity or exercise, certain weather conditions, etc.) :

2. In which sport can your child fully participate?

3.Does he/she do breathing exercises that are helpful in managing asthma?

4. Does your understand asthma, and what needs to be done to manage it?

5. if medication(s) are used, please provide the following information:
Name of medication and dose
Frequency of administration
Any side effects that your child has experienced
Circumstances in which additional doses should be administered.

6. Approximately how often does your child have an acute episode?

7. How would you like the church to treat an episode of asthma?

8. If your child does not respond to medication, what action would you advise the church personnel to take?

Comments:

INDIVIDUAL EMERGENY HEALTH PLAN FOR ANAPHYLAXIS for ___/___ Year

(Anaphylaxis is a potentially life-threatening allergic reaction. Act quickly.)

Place Picture Here

Name:_____ Date of Birth:_____
Doctor:_____ Parent/Guardian:_____
Phone:_____ Phone:_____

DELEGATES TRAINED IN THE USE OF EPINEPHRINE AUTO-INJECTORS:
_____ _____

☐ Asthmatic (check YES- Child has higher risk of severe allergic reaction. Epinephrine should be given first (before asthma medication) in case of a reaction with any breathing symptoms.

ALLERGEN(S): _____

Medications and Dosage: **Child's Weight:_____lbs.**

☐**Epinephrine Auto-Injector, Jr**. 0.15mg intramuscularly prn anaphylaxis and all 911. May repeat once as indicated below of symptoms do not improve within 20 minutes of 1st dose or return of symptoms.

☐**Epinephrine Auto-Injector**, 0.3 mg intramuscularly prn anaphylaxis and call 911.may repeat once as indicated below if symptoms do not improve within 20 minutes of 1st dose or return of symptoms.

☐**Benadryl** ____mg. po q 4-6 hrs prn allergic reaction.

☐**Other antihistamine**:_____ ____mg. po q____hrs prn allergic reaction.

CAUTION	**Epinephrine**	**Epinephrine 2nd Dose**	**Antihistamine**
No symptoms and suspected ingestion of allergen	☐	☐	☐
No symptoms and known ingestion of allergen	☐	☐	☐
Nose/Eyes: Hayfever-like symptoms: runny itchy Nose, red eyes	☐	☐	☐
Skin (1): Localized hives and/ or localized itchy rash	☐	☐	☐

EMERGENCY	**Epinephrine**	**Epinephrine 2nd Dose**	**Antihistamine**
Mouth: Itching, tingling or swelling of lips, tongue or mouth	☐	☐	☐
Skin (2): Hives and/or itchy rash on more than one part of the body, swelling of face or extremities	☐	☐	☐
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐	☐	☐
Throat: Hacking cough, tightening of throat, hoarseness, difficulty swallowing	☐	☐	☐
Lung: Shortness of breath, wheezing, shot, frequent, shallow cough	☐	☐	☐
Heart: Weak pulse, low blood pressure, fainting, dizzy, pale, cyanotic (blueness)	☐	☐	☐
Multiple: Symptoms from2 or more of the above categories	☐	☐	☐

For Minor Only:

☐This child is capable and had been instructed in the proper method to self- administration of the Epinephrine Auto-Injector in accordance with New Jersey Law.

☐This child is NOT approved to self-medicate.

☐This child MAY CARRY the Epinephrine Auto-injector.

☐This child MAY NOT CARRY the Epinephrine Auto-injector.

Calvary Chapel Old Bridge, their employees/agents are not liable for any complications arising from the administration of the Epinephrine Auto-injector or other medication.

This child is my patient and I have ordered this above treatment plan

_____
Physician Signature & Stamp (Below) Date

I authorized the administration of above for my child, to be followed by transportation to _____ (or nearest) Hospital if Epinephrine is given

_____
Parent/Guardian Signature Date