

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?

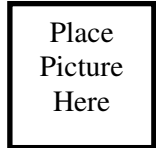
8. If your child does not respond to medication, what action would you advise the church personnel to take?

Comments:

INDIVIDUAL EMERGENCY HEALTH PLAN FOR ANAPHYLAXIS for ___/___ Year

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

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 call 911. May repeat once as indicated below if 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No symptoms and known ingestion of allergen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose/Eyes: Hayfever-like symptoms: runny itchy Nose, red eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin (1): Localized hives and/ or localized itchy rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EMERGENCY

Epinephrine Epinephrine 2nd Dose Antihistamine

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

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