easterseals Colorado

Day Camp Application Packet

Yay! Camp 2022

Dear Family and Camper,

We would like to welcome you to Easterseals Colorado Day Camp! We are looking forward to a fantastic summer!

The enclosed forms *must* be completed and returned by mail *prior* to your child attending either day camp. This packet is required of all participants at this time. If you require additional copies, visit our website at www.eastersealscolorado.org.

In addition to the forms, the **one-time non-refundable annual registration fee of $40/child must be submitted with your application**. Please write checks payable to Easterseals Colorado.

Day Camp fees for the 2022 summer: Yay! Camp is $95 per day for campers that require 1:1 staff ratio. $85 per day for campers that require a 2:1 ratio or higher. Camperships may be available. ****See Page 19****

Summer 2022 Yay! Camp will run Mondays through Thursdays from 8:30 a.m. to 4:00 p.m. from **June 13 to July 21, 2022** (Closed July 4 and 5, 2022) at **Cougar Run Elementary School**, 8780 Venneford Ranch Rd, Highlands Ranch, CO 80126. Day Camps will provide snacks for each child. You will be required to provide a lunch. Extended hours must be arranged prior to day of camp and will have additional fees depending on time needs.

Available dates are listed on Page 19 of this Packet. Please mark the dates you are planning on attending.

The Yay! Camp application deadline is May 1, 2022. Please use the following checklist to verify that all information has been submitted prior to May 1, 2022:

- ☐ Day Camp Application *[Pages 2-7]*
  - ☐ **$40 One-Time Non-Refundable Registration Fee for 2021 [Page 2]*
  - ☐ **Copy of Medicaid/Medicare/Insurance Card [Page 3]*
  - ☐ **Recent Photo of Camper [Page 3]*
- ☐ Participant Health Profile *[Pages 8-12]*
- ☐ Emergency Sheet *[Page 13]*
- ☐ Notice of Privacy Practices *[Pages 14-16]*
- ☐ Agreement, Consent and Release *[Pages 17-18]*
- ☐ Days Attending *[Page 19]*
- ☐ Demographics Information *[Page 20]*
- ☐ Immunization Record *[Pages 21-24]*
- ☐ Authorization for the Administration of Medication *[Pages 24-26]*
  - **One Form for Each Medication to be Given at Day Camp is Required.*
  - *Each Child Must Have One Form for Sunscreen [Unless a Sunscreen Allergy or Adverse Reaction is Listed on Page 8].*
  - *Without Sunscreen, a Child Will Not be Allowed to Play Outside.*
- ☐ Allergy and Anaphylaxis Emergency Care Plan and Medication Orders - *[Page 27-28]*
- ☐ Seizure Action Plan - *If Applicable - [Page 29]*
- ☐ Asthma Action Plan - *If Applicable - [Page 30]*
- ☐ Behavior Modification Plan from School - *If Applicable - [Page 31-32]*

If you have questions, please feel free to contact us by phone or email. We would be happy to answer any question you may have regarding Day Camps.

See you soon!

Krasimir Koev
Chief Operating Officer
303.233.1666 x 407
kkoev@eastersealscolorado.org

Peggy Brown
Day Camp Coordinator
720.339.7202
pbrown@eastersealscolorado.org

DAY CAMP APPLICATION

Participant Information

Participant Name: _____ (*First*) _____ (*Middle*) _____ (*Last*)

Nickname: _____ Date of Birth: _____ Gender: _____ Ethnicity: _____

Primary Diagnosis: _____

_____

_____

Secondary Diagnosis: _____

_____

_____

Funding Policy

_____ (*Initial*) I have read and understand the Funding Policy.

Type of Funding *(Check One)*:

☐ Self Pay ☐ Agency Funding ☐ Scholarship

The Camper's Fees will be Paid by *(Check One. If 'Other', Fill in the Blank)*:

☐ Parents ☐ Guardians ☐ Self ☐ Agency ☐ CCB ☐ Other: _____

The Camper's Bill should be Sent to:

Contact Person/Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Check the following that apply:

☐ I will pay the full camp fee. (*Payment is due by the week prior to the attending week of camp.*)

☐ I will be partially/fully funded by an Agency or CCB.

No refunds will be made if a Camper leaves Day Camp because of behavior problems or is sent home by the Camp Director.

(continued)

DAY CAMP APPLICATION *(Continued)*

Funding Policy *(Continued)*

To Pay by Credit Card, Circle One: VISA MASTERCARD

Cardholder's Name (PRINT): _____

Account Number: _____

Expiration Date: _____ CCV: _____

Cardholder's Signature: _____

Amount to be Charged: _____ Billing Zip Code for Card: _____

☐ Provide Documentation if Alternative Funding, other than Self Pay, is used for the Participant.

_____ _____
Signature of Parent/Legal Guardian #1 *Date*

_____ _____
Signature of Parent/Legal Guardian #2 *Date*

Medical Insurance

Insurance Name: _____ Policy/Group Number: _____

Medicaid Number: _____ Medicare Number: _____

☐ Provide a copy of the Insurance/Medicaid/Medicare Card to be used for urgent care and/or emergency services only.

☐ Provide a recent photo for identification of the participant/camper.

Parent/Legal Guardian #1

Name: _____
First *Last*

Physical Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Email: _____

(continued)

DAY CAMP APPLICATION *(Continued)*

Parent/Legal Guardian #2

Name: _____
First *Last*

Physical Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Email: _____

Is anyone not allowed to pick up the participant/camper from Day Camp?

☐ Yes ☐ No

If Yes, please specify: _____

_____

Emergency Contacts

In the event the parent/legal guardian cannot be contacted, an emergency contact will be called. Emergency contacts must show valid picture identification when picking up the participant/camper. Only those people listed below, in addition to the parents/legal guardians, may pick up the participant/camper.

Emergency Contact #1

Name: _____ Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact #2

Name: _____ Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

(continued)

DAY CAMP APPLICATION *(Continued)*

Emergency Contacts *(Continued)*

Emergency Contact #3

Name: _____ Relationship to Participant: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Pick-Up Policy/ Late Pick-Up Policy / Sick or Behavioral Pick-Up Policy

I understand the participant will only be released to a Parent, Legal Guardian, or Emergency Contact. An Emergency Contact must have valid picture identification for the participant to be released. Participants are to be picked up no later than 4:00 p.m. (unless otherwise arranged). The participant may not return to the program if two or more late pick-ups occur. Sick participants or participants experiencing behavioral issues must be picked up within one hour of the notification call.

I have read and understand the Pick-Up Policy and will abide by such policy to ensure the safety of all participants.

_____ _____
Signature of Parent/Legal Guardian #1 *Date*

_____ _____
Signature of Parent/Legal Guardian #2 *Date*

Medications

A complete medication profile is necessary in the event of an emergency. Include all prescribed and over the counter medications the participant may take (even while not attending Easterseals Colorado day camp) including creams, sunscreens, acetaminophen, and ibuprofen.

Medication #1: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

(continued)

DAY CAMP APPLICATION *(Continued)*

Medications: *(Continued)*

Medication #2: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #3: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #4: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #5: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

Medication #6: _____ Dose: _____

Times Given: _____ To be Given at Day Camp: ☐ Yes ☐ No

How to Administer the Dose: _____

Reason Prescribed: _____

(continued)

DAY CAMP APPLICATION *(Continued)*

Medication Policy

Day Program staff may only administer medications under the direction of the participant's physician. All medications must be given to the Discovery Club Nurse/ Day Camp Directors for safe storage.

Prescribed medications must be in the original container and include the original pharmacy label.

Over the counter medications (such as diaper creams, sunscreens, Tylenol for headaches, etc.) must be in the original container. A written prescription from the health care provider for the medication must be on file. The medication will be given only for the reason prescribed by the health care provider.

I understand that I must supply Day Programs with any prescribed or over the counter medications to be given to the participant.

All documented prescriptions from the health care provider will remain valid for one year, unless otherwise noted by the health care provider. Medications expired per the manufacturer or pharmacy label cannot be given to the participant. I understand that medication will be destroyed if not picked up within one month following the last program day attended.

I have read and understand the Medication Policy and hereby request medications to be administered by Day Program personnel.

_____ _____

Signature of Parent/Legal Guardian #1 *Date*

_____ _____

Signature of Parent/Legal Guardian #2 *Date*

PARTICIPANT HEALTH PROFILE

Participant Name: _____
First *Middle* *Last*

Nickname: _____ Date of Birth: _____ Gender: _____

Primary Diagnosis: _____

_____

Secondary Diagnosis: _____

_____

Surgeries/Dates: _____

_____

Food Allergies: _____

What Happens: _____

Treatment Required: _____

Environmental Allergies: _____

What Happens: _____

Treatment Required: _____

Medication Allergies: _____

What Happens: _____

Treatment Required: _____

Are any of the Allergies severe requiring rescue medication? ☐ Yes ☐ No
☐ If Yes, please complete the Allergy and Anaphylaxis Emergency Care Plan *[Pages 27-28]*.

☐ Provide a copy of the Participants Updated Immunization Record *[Pages 21-23]*.

Communications/Speech
☐ Verbal ☐ Non-Verbal ☐ Gestures ☐ Sign Language

Augmentative Communication Device/Adaptive Device
☐ Communications Board ☐ Dynavox ☐ Fingerspelling

Special Instructions: _____

(continued)

PARTICIPANT HEALTH PROFILE *(Continued)*

Hearing

☐ Normal ☐ Partially Impaired ☐ Total Loss

Adaptive Devices

☐ Hearing Aid (site: _____) ☐ Cochlear Implant (site: _____)

Special Instructions: _____

_____

Vision

☐ Normal ☐ Impaired ☐ Blind
☐ Right Eye ☐ Left Eye ☐ Both Eyes

Adaptive Devices

☐ Glasses ☐ Patch ☐ Contacts

Special Instructions: _____

_____

Mobility

☐ Walks ☐ Scooter ☐ Wheelchair ☐ Crutches ☐ Cane ☐ Walker ☐ Other: _____

Adaptive Devices

☐ Helmet ☐ Braces (site: _____) ☐ Prosthesis (site: _____)

Special Instructions: _____

_____

Transfers

☐ No Assist ☐ Standby ☐ Pivot ☐ Two-Person Assist ☐ Total Assist
☐ Weight Bearing ☐ Non-Weight Bearing

Adaptive Devices

☐ Lift ☐ Gait Belt ☐ Body Sling

Special Instructions: _____

_____

Feeding

☐ No Assist ☐ Partial Assist ☐ Total Assist

(continued)

PARTICIPANT HEALTH PROFILE *(Continued)*

Diet

☐ Regular ☐ Soft ☐ Pureed ☐ Liquid ☐ Special Diet/Restrictions:_____

Adaptive Devices

☐ Gastrointestinal Tube ☐ Nasogastric Tube

☐ Formula Feedings (Type:_____ Amount:_____ Times to be Given:_____)

☐ Free Water (Amount: _____ Times to be Given:_____)

Check Residuals:
☐ Yes ☐ No

Feeding Pump:
☐ Yes (Rate:_____) ☐ No

Gravity Feed:
☐ Yes ☐ No

Special Instructions: _____

_____

Hand and Face Washing

☐ Normal ☐ Partial Assist ☐ Total Assist

Special Instructions: _____

_____

Toileting

☐ Normal ☐ Incontinent (Bowel, Bladder, Both) ☐ Needs Reminders ☐ Catheter

Surgical Diversion

☐ Ostomy ☐ Mitrofanoff

Toileting Aids

☐ Diapers/Briefs ☐ Urinal ☐ Catheter ☐ Tampons/Pads ☐ Wet Wipes

Schedule/Frequency/Special Instructions:_____

_____

Dressing

☐ Normal ☐ Partial Assist ☐ Total Assist

Types of Latches Needing Assist

☐ Buttons ☐ Zippers ☐ Snaps ☐ Velcro ☐ Shoe Laces

Special Instructions: _____

_____

PARTICIPANT HEALTH PROFILE *(Continued)*

Seizures

☐ Yes ☐ No

☐ If Yes, submit the Seizure Action Plan completed by Health Care Provider *[Page 29].*

Type of Seizure: _____

Date of Last Seizure: _____

Describe the Seizure Activity: _____

_____

_____

Describe the Postictal Phase: _____

_____

_____

Asthma/Reactive Airway Disease

☐ Yes ☐ No

☐ If Yes, submit the Asthma Action Plan completed by Health Care Provider *[Page 30].*

Oxygen Use

☐ Yes ☐ No

☐ If Yes, Prescription from the Health Care Provider must be on file

Adaptive Devices

☐ Nasal Cannula ☐ Mask

Flow Rate/Flow Range: _____

Monitoring

☐ Pulse Oximeter (Parameters _____ to _____)

(continued)

PARTICIPANT HEALTH PROFILE *(Continued)*

In the past year, has there been any history of behaviors that are inappropriate or destructive/dangerous to self, others, or property?

☐ Yes ☐ No

☐ If Yes, submit the Behavioral Modification Plan from School *[Pages 31-32]*.

Describe the Behaviors: _____

_____

_____

_____

Does your child have a history of running away or wandering?

☐ Yes ☐ No

****All Campers Must Submit a Current Immunization Record prior to Attending Camp.****

The Participant Health Profile is used to determine if the participant's needs (physically, developmentally, and emotionally) may be safely met by Easterseals Colorado's day programs. The information provided is accurate and true to the best of my knowledge.

_____ _____
Signature of Parent/Legal Guardian #1 *Date*

_____ _____
Signature of Parent/Legal Guardian #2 *Date*

Acute Illness Exclusion

Easterseals Colorado wants to maintain a healthy environment for all participants and staff, and requests no child with acute illness attend any program.

_____ _____
Signature of Parent/Legal Guardian #1 *Date*

_____ _____
Signature of Parent/Legal Guardian #2 *Date*

Exclusion Policy Based on Needs

If the participant's needs exceed the service capacity of the program, the participant may be excluded from the program.

_____ _____
Signature of Parent/Legal Guardian #1 *Date*

_____ _____
Signature of Parent/Legal Guardian #2 *Date*

EMERGENCY SHEET

Name: _____ Date of Birth: _____ Program/Site: _____

Address: _____ Phone Number: _____

Allergies (Medications, Food, and/or Environmental). Describe (If none, please write NO Allergies): _____

_____

Current Medications: _____

_____

List any Health Conditions that may have Implications for Emergency Care: _____

_____

Emergency Contact #1

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Emergency Contact #2

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Medical Contact Information

Doctor Name: _____ Phone Number: _____

Address: _____

Dentist Name: _____ Phone Number: _____

Address: _____

Preferred Hospital Name: _____ Phone Number: _____

Address: _____

☐ I have voluntarily provided the above contact information and authorize Easterseals Colorado and its representatives to contact any of the above on my behalf in the event of an emergency. I also give permission for Easterseals Colorado to seek medical assistance in the event of a medical emergency for my child.

_____ _____

Signature of Parent/Guardian *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/PARTICIPANT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your/ participant protected health information, to notify you of our legal duties and privacy practices with respect to your/ participant health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your/ participant rights concerning your/ participant information. Our duties and your/ participant rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your/participant health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your/ participant information for purposes of treating you/ participant. For example, we may disclose your/ participant information to another health care provider so they may treat you/ participant; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your/ participant information to obtain payment for services provided to your/ participant. For example, we may disclose information to your/ participant health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your/ participant information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your/ participant information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, to report deaths or certain crimes.

NOTICE OF PRIVACY PRACTICES *(Continued)*

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your/ participant information as described below.

- To a member of your family, relative, friend, or other person who is involved in your/ participant healthcare or payment for your/ participant healthcare. We will limit the disclosure to the information relevant to that person's involvement in your/ participant healthcare or payment.
- To maintain our facility directory. If a person asks for you/ participant by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.
- To contact you/ participant to raise funds for Easterseals Colorado. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your/ participant health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your/participant care or payment for your/ participant care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you/ participant or others.
- You may request that your/ participant protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your/ participant protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

NOTICE OF PRIVACY PRACTICES *(Continued)*

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your/ participant privacy rights have been violated. You may file a complaint with us by notifying Melissa Angel. All complaints must be in writing. We will not retaliate against you/ participant for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Melissa Angel
Vice President of Human Resources
303.233.1666 x 410
393 S Harlan St, Suite 250
Lakewood, CO 80226
mangel@eastersealscolorado.org

8. Effective Date. This Notice is effective March 1, 2022.

_____
Name

_____ _____
Signature Date

_____
Parent/Guardian Name

_____ _____
Signature Date

AGREEMENT, CONSENT AND RELEASE

With the understanding that Easterseals Colorado will make every reasonable effort to prevent accidents, injuries or other mishaps, I acknowledge the following:

_____ *(initial)* The undersigned agrees to indemnify and hold harmless Easterseals Colorado – Day Camps for any and all claims, demands, costs, expenses, including reasonable attorney's fees that Easterseals Colorado may suffer as a result of any claim, action, demand or judgment against it arising from the attendance at camp by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify the Easterseals Colorado from any act of negligence or fault on the part of Easterseals Colorado, its officers, agents or employees.

_____ *(initial)* The undersigned does consent that photographs, video or motion pictures may be taken of the named applicant during the camp period, and that said photographs, video or motion pictures may be published in newspapers, magazines, television, web site, publicity releases and/or other media.

_____ *(initial)* The undersigned, in case of emergency and in the event the undersigned cannot be reached by telephone, does hereby give permission for medical treatment by a physician or hospital selected by the Camp Director. Such permission shall include any and all medical treatment which is necessary or desirable in the absolute discretion of any such physician or hospital. This medical care shall include, but is not limited to, examinations, treatments, immunizations, injections, anesthesia, surgery, and other procedures, etc.

_____ *(initial)* The undersigned does hereby agree to allow participation of applicant in all camp activities (except those restricted).

_____ *(initial)* The undersigned gives permission for the applicant to ride in vehicles operated or leased by the Easterseals Colorado.

_____ *(initial)* The undersigned recognizes the right of the Camp Director, in his/her absolute discretion, to terminate a camper's stay at any time due to disciplinary or medical actions which might jeopardize the camper's or others' health and safety at camp. The undersigned further agrees to pick up the camper immediately upon being notified of such termination. Full camp fees are nonrefundable in case of above mentioned situations.

_____ *(initial)* The undersigned agrees to pay the full camp fee if the camper cancels one week or less prior to the check in day. This includes not arriving on check in day.

_____ *(initial)* The undersigned agrees not to send the applicant to Easterseals programs if he or she has been exposed to a contagious disease within three (3) weeks of the starting date of camp, and to notify Camp Director if this situation arises.

(continued)

AGREEMENT, CONSENT AND RELEASE *(Continued)*

_____ *(initial)* Weapons, pets, drugs and alcohol are not allowed at Summer Day Camp. An exception may be made for trained guide dogs for campers who require their services. The dog's owner assumes all responsibility for the care and actions of the dog. The dog must be free of disease and have a current rabies license or tag. Dogs that exhibit any behaviors that put Easter Seals' staff, campers or visitors at risk will not be permitted to remain. Costs to have the animal removed from the camp will be at the owner's expense. A copy of the dog's vaccines is required.

_____ *(initial)* If someone other than the undersigned is to pick up the applicant at the end of the camp session, such person must present written authorization from the undersigned. I do hereby authorize to pick up camper.

_____
Name

_____ _____ _____
Address City State

_____ *(initial)* Please list anyone in particular you do NOT want to pick up your child or adult:

_____

_____

In witness where of I have here unto executed this Agreement, Consent And Release on this date:

_____
Legal Guardian's Printed Name

_____ _____
Legal Guardian's Signature Date

YAY! CAMP ATTACHMENT

LOCATION: Cougar Run Elementary School, 8780 Venneford Ranch Rd, Highlands Ranch, CO 80126

Please check the following dates the camper will be attending Yay! Camp:

Monday	**Tuesday**	**Wednesday**	**Thursday**
☐ June 13	☐ June 14	☐ June 15	☐ June 16
☐ June 20	☐ June 21	☐ June 22	☐ June 23
☐ June 27	☐ June 28	☐ June 29	☐ June 30
CLOSED JULY 4 *[July 4th Holiday]*	CLOSED JULY 5 *[July 4th Holiday]*	☐ July 6	☐ July 7
☐ July 11	☐ July 12	☐ July 13	☐ July 14
☐ July 18	☐ July 19	☐ July 20	☐ July 21

FINANCIAL REMINDER:

There is a one-time non-refundable annual registration fee of $40 per camper. Daily camp fee cost is $95 per day for campers that require a 1:1 ratio and $85 per day for campers that require a 2:1 ratio or higher.

(The annual registration fee is due with the application, which must be submitted by May 1, 2022. The payment for daily camp fees are due by the week prior to the attending week.)

Per the signed Agreement, Consent and Release Form, a full daily fee will be due if the camper cancels one week or less prior to check-in day. This includes not showing up on check-in day. If camper's funding source is through a Community Center Board (CCB), the daily fee will be due and covered by the camper's family. We advise all families to take a *"realistic approach"* when marking days that the camper will attend. Unless you are absolutely certain that your camper can attend every single day of Yay! Camp's 2022 schedule, please do not mark all dates. You can always request additional days after submitting your application, and if there is availability, we will approve such requests.

Developmental Pathways has scholarship funding for residents of Arapahoe and Douglas Counties who are receiving no services through Developmental Pathways.

For more information to see if you qualify contact:
Marilyn Udeen
m.udeen@dpcolo.org

DEMOGRAPHICS INFORMATION

This information will be compiled and used for reports to Easterseals National, foundations, and for grant applications. Actual camp costs are $125/day per camper. To keep costs for each camper at the current rate, this information is needed to receive donations, contributions, and for grant purposes.

This information is in regards to the camper: (Please check the correct information).

Education:

- ☐ Less than 12 years
- ☐ High School Graduate or GED
- ☐ Some College or Associate Degree

Ethnicity:

- ☐ Asian American
- ☐ African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Multiple Ethnicities

Household Income:

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 and above

Household Count *(If the camper is in a group home or host home, only the camper's information is required. If the camper is still living at home, total household count and income is required)*:

_____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required Vaccines

	Immunization date(s) MM/DD/YY							Titer Date* MM/DD/YY
Hep B Hepatitis B								
DTaP Diphtheria, Tetanus, Pertussis (pediatric)								
Tdap Tetanus, Diphtheria, Pertussis								
Td Tetanus, Diphtheria								
Hib *Haemophilus influenzae* type b								
IPV/OPV Polio								
PCV Pneumococcal Conjugate								
MMR Measles, Mumps, Rubella								
Measles								
Mumps								
Rubella								
Varicella Chickenpox								

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended Vaccines

	Immunization date(s) MM/DD/YY							
HPV Human Papillomavirus								
Rota Rotavirus								
MCV4/MPSV4 Meningococcal								
Men B Meningococcal								
Hep A Hepatitis A								
Flu Influenza								
COVID-19								
Other								

Health care provider Signature or Stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: May 2021

Immunization

Certificate of Medical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak. Medical exemptions need to be filed only once unless the student's information or school changes.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: ☐ Female ☐ Male ☐ X	

Parent/Guardian Completing This Form:

☐ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		☐ Check if Not Applicable
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry

Check each vaccine declined:		List medical contraindication(s) for each vaccine declined:
☐	Hepatitis B	
☐	Diphtheria, tetanus, pertussis (DTaP, Tdap)	
☐	Haemophilus influenzae type b (Hib)	
☐	Inactivated poliovirus (IPV)	
☐	Pneumococcal conjugate (PCV13)	
☐	Measles, mumps, rubella (MMR)	
☐	Varicella (chickenpox)	

Statement of Exemption

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

REQUIRED Signature:_____ Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

REQUIRED: _____ Professional License Number:_____

(State/Territory)

Under Colorado law, you have the option to exclude your child's/your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Last Reviewed August 2021

Immunization

Certificate of Nonmedical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, a nonmedical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.[1,2] From kindergarten through 12th grade, a nonmedical exemption must be filed every year during the student's school enrollment/registration process.[1] Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: ☐ Female ☐ Male ☐ X	

Parent/Guardian Completing This Form: ☐Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District: ☐Check if Not Applicable		
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry - Place an "X" next to each vaccine for which you are claiming a nonmedical exemption.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV13)
	Hepatitis B		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student themself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, www.spreadthevaxfacts.com/, www.ImmunizeForGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child's/my immunization record.[3]

REQUIRED Signature: _____ Date: _____
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

REQUIRED Print Name, Title, and Signature:_____ Date:_____
Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)
REQUIRED Colorado Professional License Number:_____

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[1] Colorado Board of Health rule 6 CCR 1009-2: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7698&fileName=6%20CCR%201009-2

[2] 2021 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a nonmedical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Last Reviewed September 2021

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT EASTERSEALS COLORADO'S DAY CAMPS

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication.

Complete one form for each medication to be administered at Easterseals Colorado Day Programs, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

_____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, Frequency: _____

Relevant Side Effects: ☐ None Expected ☐ Yes (Specify: _____)

ALLERGIES: ☐ No ☐ Yes (Specify: _____)

Medication shall be administered from: _____ to _____
Month / Day / Year *Month / Day / Year*

Prescriber's Name/Title: _____

_____

Telephone: _____

Address: _____

_____

Use for Prescriber's Stamp

_____ _____
Prescriber's Signature *Date*

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT EASTERSEALS COLORADO'S DAY CAMPS

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication.

Complete one form for each medication to be administered at Easterseals Colorado Day Programs, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

_____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, Frequency: _____

Relevant Side Effects: ☐ None Expected ☐ Yes (Specify: _____)

ALLERGIES: ☐ No ☐ Yes (Specify: _____)

Medication shall be administered from: _____ to _____
Month / Day / Year *Month / Day / Year*

Prescriber's Name/Title: _____

_____

Telephone: _____

Address: _____

_____

Use for Prescriber's Stamp

_____ _____
Prescriber's Signature *Date*

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT EASTERSEALS COLORADO'S DAY CAMPS

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) for the nurse or designated trained personnel to administer medication.

Complete one form for each medication to be administered at Easterseals Colorado Day Programs, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

_____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, Frequency: _____

Relevant Side Effects: ☐ None Expected ☐ Yes (Specify: _____)

ALLERGIES: ☐ No ☐ Yes (Specify: _____)

Medication shall be administered from: _____ to _____
Month / Day / Year *Month / Day / Year*

Prescriber's Name/Title: _____

_____

Telephone: _____

Address: _____

_____

Use for Prescriber's Stamp

_____ _____
Prescriber's Signature *Date*

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG:	Short of breath, wheeze, repetitive cough
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Swelling of the tongue and/or lips
HEART:	Pale, blue, faint, weak pulse, dizzy
SKIN:	Many hives over body, widespread redness
GUT:	Vomiting or diarrhea (if severe or combined with other symptoms
OTHER:	Feeling something bad is about to happen, Confusion, agitation

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE:	Itchy, runny nose, sneezing
SKIN:	A few hives, mild itch
GUT:	Mild nausea/discomfort

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

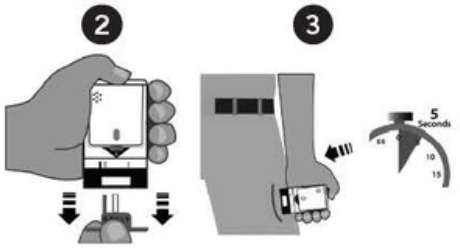
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

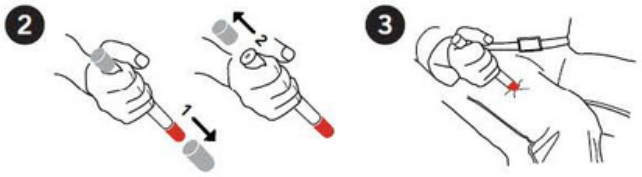
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



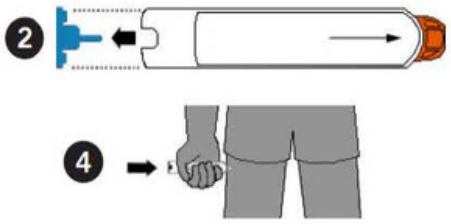
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.	
Child Name:	Birth date:
Parent/Guardian Contact:	Phone:
Emergency Contact:	Phone:
School:	Grade:

Place child's photo here

Triggers: tiredness flashing lights illness hunger temperature Other: _____
Seizure Aura (if any):_____
Seizure history: Convulsive Focal Absence Date of last known seizure _____
Describe:_____
Antiseizure Medication Taken at Home **Common side effects**

Other Seizure Treatments/Special Diet Therapy:

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my child.

PARENT SIGNATURE _____ DATE _____ SCHOOL NURSE SIGNATURE _____ DATE _____ 504 plan IEP

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

IF YOU SEE THIS:	**DO THIS:**
Convulsive Generalized Tonic Clonic: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. **Administer rescue treatments as marked below.**
Focal: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes.These seizures usually last 1-2 minutes.	1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. 6. **Administer rescue treatments as marked below.**
Absence: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

Rescue Treatments

Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops.
Give rescue medications below if seizure does not stop within _____minutes.

If seizure lasts longer than ___ minutes administer:

Diastat ___mg rectally Midazolam ___mg in the nose Clonazepam ___mg in the cheek

Multistep seizure rescue plan – Please see attached letter for details.

If cluster of ___ or more seizures in _____ min administer:

Diastat ___mg rectally Midazolam ___mg in the nose Clonazepam ___mg in the cheek

Multistep seizure rescue plan – Please see attached letter for details.

If emergency medication is administered: Call 911 immediately or Call 911 if seizure does not stop within 5 minutes

Other:

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

If no emergency medication is at school and the child is experiencing seizures:
Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE _____

May/2019

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware ***911 may be called if a quick relief inhaler is not at school*** and my child/youth is experiencing symptoms.

_____ _____

Parent/Guardian Signature **Date**

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other**: _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

_____ _____ _____

Health Care Provider Signature **Print Provider Name** **Date**

Good for 12 months unless specified otherwise in district policy.

_____ _____ _____

Fax **Phone** **Email**

_____ _____

School Nurse/CCHC Signature **Date**

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021

Legal Name of Student	State Student ID (SASID)	Date of Birth	Date

Student's Grade	Parent/Guardian/ESP Name(s)	Parent/Guardian/ESP Email	Parent/Guardian/ESP Phone Number

BEHAVIOR INTERVENTION PLAN (BIP)

1. Sources of Information:
List sources of information used in FBA, both formal and informal, to develop this plan.

2. Strength Based Profile
Identify skills and interests, positive relationships, pro-social behaviors, family and community supports, and other protective factors.

3. Functional Behavioral Assessment (FBA) Summary Statement
Describe specific problem behavior and summary/hypothesis statement from FBA.

4. BIP Strategies/Outcomes Worksheet
Based on hypothesis, in the table below, identify the strategy, what will be done, when and where the strategy will occur.

Setting Event Strategies (Reduce impact of setting events)	**Antecedent Strategies** (Decrease likelihood that behavior will occur)	**Behavior Teaching Strategies [Alternative Behaviors]** Increase the likelihood that the appropriate replacement behavior will occur through instruction)	**Reinforcement Strategies [Consequence]** (When student demonstrates the desired behavior, the need behind the behavior is met –e.g. obtain or avoid)

5. Crisis Intervention Plan
If the student's behavior has the potential to produce harm, attach a crisis intervention plan.

6. Evaluation
Indicate how the plan will be measured and by whom. Identify the desired performance level for either increasing the occurrence of the identified alternative behavior(s) or decreasing the occurrence of the behavior of greatest concern (criterion for success).

Continuous Progress Monitoring Method: Person Responsible:

Criterion for Success: Follow-up Meeting Date:

7. Contextual Fit
Supports, resources and training needed for personnel to implement this plan in the current educational environment.

8. Communicating the Behavior Intervention Plan
The plan will be communicated to the following people (i.e. bus driver, clinic aid, school resource officer, etc.)

Person to be contacted:	How contact will be made:	Person responsible for contact:	Date/Frequency of contact:

Who will communicate revisions and updates internally and externally?

9. Team Members:
Teacher, parent, student, mental health worker, community agency personnel, related service provider etc.

Parent	Other
Parent	Other
Student	Other
Case Manager	Other

PARENT PROVIDED A COPY OF PLAN