PARTICIPANT FORMS

These Participant Forms are for children attending:

- Club Rec/Super Sports/Theatre
- H.R.C.
- Kids' Corner Preschool Program
- Summer Exploration
- Counselors in Training (CIT)

Please complete and print the forms. Please bring the forms the first day your child attends the program. If your child is attending multiple weeks of the same program, you only need to bring the forms the first week they attend.

Please complete the forms for EACH child (i.e. siblings should not share forms).

You do not need to complete all of the forms. See below:

- **Pages 1 & 2: EVERYONE should complete**
- Pages 3-6 are to expand on allergies and other medical concerns as needed.
- Pages 7 & 8: Developmental Information - **Kids' Corner (Preschool) Participants (ONLY!)**

Questions? Please call 781-316-3880

REQUIRED PARTICIPANT FORMS: ARLINGTON RECREATION SUMMER PROGRAMS 2023

EMERGENCY INFORMATION FORM

PARTICIPANT INFORMATION

Participant's Name: _____ Date of Birth: _____ Grade Entering Fall 2023: _____

Allergies: _____ **Medications:** _____

Special Accommodations: _____

PARENT/GUARDIAN INFORMATION

(Please fill out all information applicable. Use N/A if not applicable)

Participant/Guardian Name: _____ Participant/Guardian Name: _____

Relationship to Child: _____ Relationship to Child: _____

Home Address: _____ Home Address: _____

Home Phone Number: _____ Home Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

Email Address: _____ Email Address: _____

EMERGENCY CONTACT INFORMATION

Required to list at least one individual other than parents/ guardians. Individuals should be local/accessible in the event of an emergency)

Name: _____ Relationship to Child: _____

Address: _____ Primary Phone Number: _____

MEDICATION REQUEST/PERMISSION

Please note children taking medication during the program are required to have a *Medication Consent Form* completed on their behalf. Participants with any type of food allergy and/or that are prescribed an EpiPen are required to have a *Food Allergy & Anaphylaxis Emergency Care Plan* completed on their behalf.

My child will need to take medication during program hours ☐

Medication: _____ Dosage: _____

Medication: _____ Dosage_____

PLEASE LIST ANY OTHER MEDICAL CONERNS BELOW:

We strive to create an environment that is accessible for all campers. Please share any information related to how we can support your child's experience this summer:

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All required forms should be brought to the program on the first day and submitted at check-in.

PICK UP PLAN/INDIVIDUALS AUTHORIZED FOR PICK UP FORM

It is strongly recommended that the pickup/drop off person (parent/guardian/individual) is the same individual throughout the week. Participants will only be released to adults that have been listed on the participant's authorized pick-up form.

To assure the safety of your child, **A PHOTO ID WILL BE REQUIRED AT PICK UP** until your counselor can positively identify that the individual picking up has done so before and is on the participants authorized pick-up list. These procedures are to guarantee the safety of your child. If someone other than the parent/guardian is picking up, a written note must be submitted to the Program Director ahead of time.

Please list all adults, **INCLUDING PARENTS,** who are authorized to pick up your child this summer. To avoid problems at pick-up time, please include anyone who may ever possibly pick up your child. A written consent letter is required for pickup by anyone not on this list. Please remember to include carpool members. Individuals must be at least 18 years old to pick up a participant.

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INDIVIDUALS AUTHORIZED FOR PICK UP

The following people are authorized to pick up my child, _____, from the Arlington Recreation summer program which they are registered for:

1. Name: _____ Relationship to Child: _____
   Address: _____ Primary Phone Number: _____
2. Name: _____ Relationship to Child: _____
   Address: _____ Primary Phone Number: _____
3. Name: _____ Relationship to Child: _____
   Address: _____ Primary Phone Number: _____

Please list any individual(s) who is **LEGALLY DENIED** access to your child. If this is the case, please email mjcurran@town.arlington.ma.us to provide additional information on the situation. Please include their name, relationship to the child, and age: _____

_____

PLEASE REMEMBER THAT ALL PEOPLE LISTED AS AUTHORIZED PICK UPS MUST COME WITH A VALID PHOTO ID

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the yellow zone more than 24 hours or is getting worse, follow red zone and call the doctor right away!

☹ Red Zone If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping

Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers

☐ School nurse agrees with student self-administering the inhalers.

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

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Please send a signed copy back to the pro[illegible] listed above.

EMERGENCY ACTION PLAN

Seizures

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

Seizure Type	Triggers	How Long it Lasts	How Often	What Happens

First Aid - STAY calm, begin timing seizure. Notify school nurse.

- ✓ Provide PRIVACY – remove other students from area
- ✓ Keep the student SAFE – remove harmful objects, don't restrain, protect head.
- ✓ Position on SIDE – turn on side if not awake, keep airway clear, do not put objects in mouth

Give Medication or Treatment

- ✓ Administer Medication: _____ Instructions: _____
- ✓ Swipe magnet for VNS (Vagal Nerve Stimulator) Instructions: _____

Get Help If:

- ✓ Lasts more than 5 minutes
- ✓ Repeated seizures longer than 10 minutes with no recovery time in-between
- ✓ Seizure does not stop after giving emergency medication
- ✓ Difficulty breathing after seizure ends
- ✓ Serious injury occurs or suspected, or seizure in water

After the Seizure

- ✓ **STAY with the student until fully recovered from seizure**
- ✓ Notify parent or guardian if student does not return to usual behavior (i.e., confused, or lethargic).

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.

EMERGENCY ACTION PLAN

Sickle Cell Disease - Pain (Vaso-occlusive) Crisis

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

A pain crisis is when the blood vessels get blocked by sickled red blood cells and the tissues don't get the oxygen they need. A pain crisis can come on suddenly or build up over a few days.
A PAIN CRISIS MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present?

- ✓ Pain or discomfort
- ✓ Headache (severe)
- ✓ Chest pain
- ✓ Bone/joint/hip pain
- ✓ Upper left, abdominal pain
- ✓ Priapism (sustained, unwanted erection)
- ✓ Vomiting
- ✓ Swelling of hands or feet

Medical Emergency - Contact the School Nurse

- ✓ Fever 101 degrees or higher
- ✓ Weakness or fatigue
- ✓ Weakness on either side of body
- ✓ Inability to speak
- ✓ Difficulty with memory
- ✓ Sudden or constant dizziness
- ✓ Blurred vision
- ✓ Changes in breathing, difficulty breathing, fast rate or harsh noisy breathing
- ✓ Noticeable change in the color of the skin, lips, fingernails

TREATMENT: Initiate care – do not delay treatment. Stop any activity. Accompany the student to the Health Office for treatment, if possible. Access assistance from the school nurse, if possible. **Never apply ice.**

TREATMENT: For medical emergencies, the school nurse is unavailable call 911 immediately and transport the student to the nearest emergency room.

Preferred hospital: _____

Doctor's Name: _____

Phone: _____

Proceed with the following care per healthcare provider's instructions:

☐ Medication _____ ☐ Hydrate: _____ Other: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.

EMERGENCY ACTION PLAN

Anaphylaxis – Life-Threatening Allergies

Student Name: _____ DOB: _____ Grade: _____

Identified Allergen(s): _____

Asthma: ☐ Yes ☐ No Other relevant health concerns: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

IMPORTANT: EACH ALLERGIC REACTION MAY INCREASE IN SEVERITY FROM PREVIOUS REACTIONS.
ALLERGIC REACTIONS CAN INCREASE IN SEVERITY QUICKLY – PROVIDE EMERGENCY CARE AS QUICKLY AS POSSIBLE

A LIFE-THREATENING ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present and severe?

- ✓ LUNG: Short of breath, wheeze, repetitive cough
- ✓ HEART: Pale, blue, faint, weak pulse, dizzy, confused
- ✓ THROAT: Tight, hoarse, trouble breathing/swallowing
- ✓ MOUTH: Obstructive swelling (tongue and/or lips)
- ✓ SKIN: Hives over body

Or is there a combination of symptoms from different body areas?

- ✓ SKIN: Hives, itchy rashes, swelling (eyes, lips)
- ✓ GUT: Vomiting, cramping pain, diarrhea
- ✓ RESPIRATORY: Runny nose, sneezing, swollen eyes, phlegmy throat
- ✓ OTHER: Confusion, agitation, feeling of impending doom

DO THIS

INITIATE CARE – do not delay treatment if anaphylaxis is suspected. When in doubt, give epinephrine.

TREATMENT: Epinephrine – Medication is at school ☐ Yes ☐ No Dosage: _____

Directions for administration: _____ ☐ Repeat dose after 5 or more minutes if needed.

☐ Treatment should be initiated immediately following exposure without waiting for symptoms (per healthcare provider).

☐ Treatment should be initiated only following the appearance of symptoms (per healthcare provider).

THEN MONITOR

PROVIDE ONGOING CARE: Stay with the student, maintain airway, do not have the student rise to an upright position. Observe for changes.

If epinephrine is given, call 911 immediately and transport the student to the nearest emergency room.

Preferred hospital: _____

Doctor's Name: _____ Date: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis.
In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.

For Kids Corner (Preschool) Only

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME _____ DATE OF BIRTH _____

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____

*Does your child use pacifier or suck thumb? _____ *When? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

Favorite foods: _____

Foods refused: _____

* Does your child eat with spoon? Fork? Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used? _____

*Are bowel movements regular? how many per day? _____

*Has toilet training been attempted? _____

How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____

Does your child become tired or nap during the day (include when and how long)?

_____

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking)

_____

SOCIAL RELATIONSHIPS How would you describe your child:

_____

_____

Previous experience with other children/daycare/school:

_____

Reaction to strangers: Able to play alone:

_____

_____

Favorite toys and
activities:_____

Fears (the dark, animals, etc.)

_____

_____

How do you comfort your child?

_____

_____

What is the method of behavior management/discipline at home:

_____

What would you like your child to gain from his/her experience at Kid Care Preschool?

_____

What are your child's strengths?

_____

_____

In what areas would you like to see your child grow?

_____

Is there anything else you would like us to know about your child?

_____

Parent/Guardian signature_____ Date_____