CENTRAL FLORIDA DREAMPLEX
ORDINARY SPORTS FOR EXTRAORDINARY PEOPLE

Date _____

I. Please help us better understand your child with special needs

Child's name_____ Grade_____ Age_____ M F

Child lives with: ____both parents ____mother ____father

guardian_____

Father's/Guardian's name_____ Cell #_____

Mother's/Guardian's name_____ Cell #_____

Primary Parent/Guardian's Email Address: _____

Child's **primary health concerns** we should be aware of:

_____

_____

2. *CARE NEEDS*

VISION: ___Typical ___Impaired ___Blind
HEARING: ___Typical ___Impaired ___Deaf ___Hearing Aid
MOTOR: ___Head control ___Rolls over ___Sits ___Crawls ___Walks
USES: ___Walker ___Crutches ___Braces ___Wheelchair
Please describe any special positioning needs your child may have: _____

_____

3. CAN COMMUNICATE WITH OTHERS USING:

Speech: ___Words ____Phrases ____Sentences ___ Babbles ___Gestures ____Sign Language
___Other (describe): _____
CAN UNDERSTAND WHAT OTHERS SAY: ___All the time ___Most of the time ___Some of the time
___Recognizes voices of family members.

ALLERGIES: (Drugs, Food, Other) _____

_____

4. EATING HABITS: Feeds self by using: ___spoon ___ fork ___hands ____Requires feeding
___Bottle fed ___Drinks from cup: ___with assistance ___by self
Special Diet: _____

5. TOILETING SKILLS:

____Toilets independently ___Diapers: ___Cloth ___Disposable
____Currently being potty trained ___Potty trained, needs assistance
____Requires catheterization Frequency/Schedule: _____

How does your child indicate a need to use the toilet? _____
Indicate special toileting needs/schedule: _____

6. BEHAVIOR: (check all that apply)

___Shy ___Outgoing
___Plays alone ___Plays in groups
___Adapts to new situations well
___Adapts to new situations with difficulty
___Responds to correction well
___Responds to correction with difficulty
___Is sometimes destructive
___Sometimes threatens others
___Sometimes hits, bites, or hurts self/others
___Sometimes attempts to run away
___Hyperactive and/or ADD

My child responds to separation from his/her parents by: _____
_____
My child is best comforted by: _____
_____
My child lets someone know what he/she wants or needs by: _____
_____
What type of play activities does your child enjoy and/or participate in? _____
_____
My child becomes upset when/or does not enjoy: _____
_____
Are there any additional concerns not already addressed: _____

_____

SIGNED: _____ DATE: _____
Parent or Guardian

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Emergency Release Form

In the event of a serious accident or illness with my child _____, and I cannot be reached, I hereby authorize the school to contact the physician or dentist and for those professionals listed below to provide protected health information.

Physician / Dentist Name	Phone Number	Address

In the event of an EMERGENCY I, _____ understand that the Central Florida Dreamplex will call the 911 Emergency Medical System immediately. To expedite care I give my permission for the school to provide medical information to the responding emergency team to initiate treatment, and transport to the nearest appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment upon arrival to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed of my child's condition and admission. I agree to be financially responsible for my child's treatment and transport.

I have reviewed the above information and give permission to:

- ☐ Call Doctor
- ☐ Call 911
- ☐ Ride in Ambulance if needed
- ☐ Treat

My Emergency Contacts if I am not available in order of who to call first is:

Last Name	First Name	Relationship	Phone Number

_____ _____

Parent Signature Date

_____

Print Parent's Name

Asthma and Allergy Foundation of America

CHILD CARE ASTHMA/ALLERGY ACTION CARD

ID Photo

Name: _____ _____

Grade: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2 _____
Name

_____ _____
Relationship Phone

Physician Child Sees for Asthma/Allergies: _____

Phone: _____

Other Physician: _____

Phone: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode**

(Check each that applies to the child)

— Animals — Bee/Insect Sting — Chalk Dust — Change in Temperature
— Dust Mites — Exercise — Latex — Molds
— Pollens — Respiratory Infections — Smoke — Strong Odors
— Food: _____
— Other: _____
Comments: _____
_____

- **Peak Flow Monitoring** (for children over 4 years old)

Personal Best Peak Flow reading: _____

Monitoring Times: _____ _____ _____

- **Control of Child Care Environment** (List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.) _____
_____

- **Daily Medication Plan for Asthma/Allergy**

	Name	Amount	When to Use
1			
2			
3			
4			

OUTSIDE ACTIVITY AND FIELD TRIPS

The following medications must accompany child when participating in outside activity and field trips:

	Name	Amount	When to Use
1			
2			
3			

Rev. 5/01

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____

_____

or has a peak flow reading at or below _____

- **Steps to take during an asthma episode:**
  1. Check peak flow reading (if child uses a peak flow meter).
  2. Give medications as listed below.
  3. Check for decreased symptoms and/or increased peak flow reading.
  4. Allow child to stay at child care setting if: _____

     _____
  5. Contact parent/guardian
  6. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after initial treatment with medication.
→ Peak flow at or below _____.
→ Hard time breathing with:
  - Chest and neck pulled in with breathing.
  - Child hunched over.
  - Child struggling to breathe.

→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

- **Emergency Asthma Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

ALLERGY EMERGENCY PLAN

- **Child is allergic to:** _____

_____

_____

- **Steps to take during an allergy episode:**
  1. If the following symptoms occur, give the medications listed below.
  2. Contact Emergency help and request epinephrine.
  3. Contact the child's parent/guardian.

- S**ymptoms of an allergic reaction include**:

  (Physician, please circle those that apply)

→**Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→**Skin:** hives; itchy rash; swelling
→**Gut:** nausea; abdominal cramps; vomiting; diarrhea
→**Lung*:** shortness of breath; coughing; wheezing
→**Heart:** pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may also need to be treated.

- **Emergency Allergy Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

Physician's Signature **Date** **Parent/Guardian's Signature** **Date** **Child Care Provider's Signature** **Date**

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Medication Administration Authorization Form

The policy is medication will only be administered if it has been prescribed by a qualified medical practicionor, is in it's orginal container and I have a signed permission form with directions.

I, _____, authorize _____
(Parent's name) (Care provider's name)

to adminsiter _____ to my child _____
(Medication) (Child's name)

with the following instructions:

Dosage:
_____

Time(s):
_____

Special Instructions (ie: on full/empty stomach, etc.) _____
_____
_____

Possible Side Effects: _____
_____
_____

_____ _____
Parent Signature Date

Time and date administered:

Date	Time	Provider Initials

MY SEIZURE PLAN

Name: _____ **Birth Date**: _____

Address: _____ **Phone**: _____

1st Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

2nd Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

SEIZURE INFORMATION

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

TRIGGERS

_____

_____

DAILY SEIZURE MEDICINE

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

OTHER SEIZURE TREATMENTS

Device Type:_____ Model:_____ Serial#:_____ Date Implanted:_____

Diatery Therapy:_____ Date Begun:_____

Special Instructions:_____

Other Therapy:_____

MY SEIZURE PLAN

SEIZURE FIRST AID

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed:_____

WHEN SEIZURES REQUIRE ADDITIONAL HELP

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"AS NEEDED" TREATMENTS (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION IF ...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed:_____

HEALTH CARE CONTACTS

Epilepsy Doctor:_____ Phone: _____
Nurse/Other Health Care Provider:_____ Phone: _____
Preferred Hospital:_____ Phone: _____
PCP or Other Doctor:_____ Phone: _____
Pharmacy:_____ Phone: _____

SPECIAL INSTRUCTIONS: _____

_____

My signature _____ **Provider signature**_____ **Date** _____

 A service of the Epilepsy Foundation

Revised April 2010

Parent School Health Information

Too Sick for School Guidelines

When should your child stay home from school and when should parents be called to pick up their child from school?

Children sent to school when they are sick cannot concentrate on content being taught in the classroom. Teachers are concerned with the health and safety issues of all children, but their main objective is to provide the best education for the children. If a teacher has to concentrate on taking care of a sick child in the classroom, this takes away valuable educational time. When there is a clinic on campus, this clinic is to maintain your child for a short period of time only. When a parent is notified their child is not well it is the parents responsibility to pick up the child within an hour. It is best practice to keep your child at home when he/she complains of feeling sick. Please remember to always provide current home, work and emergency telephone numbers where you may be reached in the event your child is sick and needs to come home. If you do not have a home or work phone we need the number of a relative or neighbor that can contact you when necessary. We understand parents must work, but arrangements need to be made for someone to pick up your child in the event of illness at school. If a child becomes very ill at school and the parents cannot be reached it may become necessary to call 911 to take the child for medical attention at parent expense.

1. A runny nose is the way many children respond to pollen, dust, chalk, or simply change of season. If it isn't a common cold, then it is possibly allergies and allergies are not contagious. The child should not miss school unless the allergic responses are severe enough to cause respiratory difficulty. Parents should send an adequate supply of tissues for the child to use during the day.

2. A bad cold or cold symptoms can indicate a severe cold, bronchitis, flu or even pneumonia. Some children may be unfortunate enough to suffer one cold after the other during the season and a common cold should not be a reason to miss school. However, good hand washing techniques, and covering the mouth and nose when coughing and sneezing should be taught and encouraged by parents as well as school personnel. Tissues should be sent to school for the child to use during the day. If the child is not acting as usual, has difficulty breathing or is becoming dehydrated, it could be serious and a visit to the child's doctor is highly recommended. Rest and plenty of fluids are always encouraged.

3. Diarrhea and vomiting make children very uncomfortable, and being near a bathroom becomes a top priority. If a child has one episode of diarrhea or vomiting, does not have a temperature and no other episode occurs the child may stay in school. However, if there are repeated episodes of either diarrhea or vomiting the child should be picked up by the parent. If the child has diarrhea and vomiting, accompanied by fever, a rash or general weakness, consulting the child's doctor is highly recommended. If any of these symptoms are present before school the parent should not send the child to school. A child can easily become dehydrated and malnourished when diarrhea and vomiting persist and can lead to a very serious, life-threatening situation for the child.

IF A SICK CHILD IS TAKEN TO THE DOCTOR, PLEASE REQUEST A NOTE FROM THE DOCTOR STATING THAT HE/SHE MAY RETURN TO SCHOOL. THIS NOTE SHOULD ALSO INCLUDE DIET RESTRICTIONS AND ANY LIMITATIONS THAT MAY BE NECESSARY.

4. An elevated temperature of 100^{o} or above is an important symptom, when it occurs along with a sore throat, an earache, nausea, listlessness, or a rash the child may be carrying something contagious. Students with a fever greater than 100^{o} may not return to school until fever free for 24 hours **without** fever reducing medicine.

5. Strep throat and Scarlet fever are two highly contagious conditions caused by a Streptococcal (bacterial) infection, the two conditions usually are recognized by a sore throat and high fever, a rash will also appear. A child with either Strep throat or Scarlet fever should be kept at home. A parent will usually take a child to the doctor for these conditions and the parent should request a medical release for the child to return to school.

6. Chicken Pox, a viral infection is not life threatening to most children, but it is very uncomfortable and extremely contagious. The child may have a fever, is itching and begins to have pink or red spots (with watery fluid centers) on the back, chest, and or face; the chances are it is chicken pox. Please notify the school if your child is diagnosed with chicken pox. It is very important that schools are made aware because some children have low functioning immune systems and chicken pox could be life threatening for them. The child with this illness should be kept at home for at least one week from the first time symptoms appeared and at least two days after the last spot appeared, whichever period is longer. The rash spots should be dry and scabbed over before returning to school.

7. Measles (Rubeola) is a viral infection that attacks a child's respiratory system, causing a dry hacking cough, general weakness, red inflamed eyes and fever. If these symptoms appear, the child should be kept at home and seen be the

child's physician immediately to prevent more serious complications. If it is a doctor confirms it is a case of measles, please notify the school so we can be alert for the symptoms in other children. The measles rash of tiny hard bumps will appear on the child's face, behind the ears and down the body. Your child's doctor must report this disease to the local Health Department. The doctor will usually advise the parents to keep the child at home several days after the rash has disappeared. WITH PROPER IMMUNIZATIONS WE HOPE THIS DISEASE WILL NO LONGER BE A PROBLEM FOR CHILDREN.

8. Conjunctivitis or pink eye is highly contagious and uncomfortable, so be aware that if your child complains of eyes burning, itching and produces a whitish discharge, the eyelashes may be matted together upon arising in the morning from sleep. Minor cases (caused by virus) and severe cases (caused by bacteria) require treatment with eye drops prescribed by the doctor. Please request the doctor provide a medical release for the child to return to school.

9. Ear infections are also contagious and, unless properly treated can cause permanent hearing damage and loss. This condition should have a doctor's evaluation. Antibiotics are usually ordered and the child should be without discharge from the ear and fever for 24 hours before returning to school. It is best to ask the doctor for a release for the child to return to school.

10. Mites and lice once brought into the home or school can quickly produce an epidemic of itching and scratching. Mites are tiny insects in the same class as spiders and ticks; they irritate the skin and cause scabies. Lice are tiny parasites (like ticks) that thrive on warm, damp scalps of children and adults. Caution your child and family members against sharing anyone's comb brush, clothes, helmets, hats, caps, scarves, or any other personal item. If your child or family member becomes a host to mites you will need to consult your physician. If it is a situation with head lice you may check with the doctor, local Health Department. Your child's school has information available for treating a head lice problem. Lice <u>cannot</u> survive longer than 48 hours away from the human host.

LAKE COUNTY SCHOOLS HAS A NO NIT POLICY, SO IF YOUR CHILD HAS LICE, HE/SHE MAY NOT RETURN TO SCHOOL UNTIL ALL LICE AND NITS ARE REMOVED.

11. Scabies is usually treated with a medication ordered by the doctor. Please ask the doctor for a release for when the child may return to school.

CENTRAL FLORIDA DREAMPLEX

MEDIA CONSENT FORM AND RELEASE FOR MINOR CHILDREN

I am the parent/guardian of_____(print full name of child) ("My Child"). I hereby grant The Central Florida Dreamplex LLC, , and their agents the absolute right and permission to use photographic portraits, pictures, digital images or videotapes of My Child, or in which My Child may be included in whole or part, or reproductions thereof in color or otherwise for any lawful purpose whatsoever, including but not limited to use in any Central Florida Dreamplex LLC publication or on the Central Florida Dreamplex LLC websites, without payment or any other consideration.

I hereby waive any right that I may have to inspect and/or approve the finished product or the copy that may be used in connection therewith, wherein My Child's likeness appears, or the use to which it may be applied.

I hereby release, discharge, and agree to indemnify and hold harmless the Central Florida Dreamplex LLC, and their agents from all claims, demands, and causes of action that I or My Child have or may have by reason of this authorization or use of My Child's photographic portraits, pictures, digital images or videotapes, including any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said images or videotapes, or in processing tending towards the completion of the finished product, including publication on the internet, in brochures, or any other advertisements or promotional materials.

I represent that I am at least eighteen (18) years of age and am fully competent to sign this Release.

THIS IS A RELEASE OF LEGAL RIGHTS.
READ IT CAREFULLY AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING

(Both parents, if possible)

PLEASE CHECK ONE OF THE BOXES BELOW THEN SIGN YOUR NAME(S)

□ CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above named child and do hereby give our/my consent without reservation to the foregoing on behalf of My Child.

□ NON----CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above named child and do **not** hereby give our/my consent without reservation to the foregoing on behalf of My Child.

_____ _____
(Guardian's Signature) (Date)

_____ _____
(Guardian's Printed Name) (Primary Phone Number)