

URGENT!

Return Completed Forms to:
Bright Lights, Inc.
5561 S 48th St., Suite 220
Lincoln, NE 68516



2010 STUDENT MEDICAL INFORMATION FORM

Student's Name: _____ Age: _____

Bright Lights Class(es) Attending: _____

Address: _____ Home or Lincoln Phone: _____

This student uses (check all that apply): Inhaler Epi-pen Insulin Other _____

**** Important:** No health support is available at locations other than our main program site, Randolph Elementary School.

You indicated on your child's registration form that s/he has a medical condition and uses prescribed medication for health management. Please complete this form (both sides) **and** the attached Medical Release Form (signature required on both forms) so we can coordinate appropriate care for your child while at the Bright Lights summer program. It is very important that we have emergency contact information.

If you have questions about this form or concerns regarding your child's participation during the summer class(es), please contact Kathy Hanrath at khanrath@brightlights.org or 420-1115 X 41. Rita McClure, LPN, will be at the main program site, Randolph Elementary School, during Bright Lights summer program weeks (436-1487).

Parent/Guardian #1 Name: _____ Work Phone: _____
Address (if different than child's): _____ Home Phone: _____

Parent/Guardian #2 Name: _____ Work Phone: _____
Address (if different than child's): _____ Home Phone: _____

Child's Doctor: _____ Phone: _____

CONDITION HISTORY

1) At what age was your child diagnosed with: Asthma _____ Allergies _____ Diabetes _____

2) My child has been hospitalized and/or received emergency room care for: breathing problems
If checked, please indicate date(s) _____ anaphylaxis episode
_____ control of blood sugar

3) Check the triggers that cause your child to have breathing problems (if known):
 Exercise Respiratory Infections Change in Temperature Animals
 Chalk Dust Pollens Molds Carpeting
 Strong Odors or Fumes Other _____
 Food: Please indicate food type(s)/ingredient(s) _____

Comments/Special Instructions: _____

4) How often does your child have asthma episodes? Weekly Number of episodes _____
 Monthly Number of episodes _____
 Yearly Number of episodes _____

(CONTINUED ON REVERSE)

SIGNS AND SYMPTOMS OF EPISODE ONSET

Check the signs your child shows when s/he is about to have: (please indicate) Breathing problems
 Anaphylaxis
 Low/high blood sugar
 Coughing Shortness of Breath Wheezing
 Restlessness Anxiety Complaints of Chest Tightness
 Nausea Difficulty Swallowing Swelling, Where: _____
 Rash, Where: _____ Flushed or Unusually Pale Skin
 Dizziness Loss of Consciousness Confusion/Slow Mental Response
 Other(s): _____

EPISODE TREATMENT AND MEDICATION

1) What usually helps your child if an episode/difficulty occurs? _____

2) List all current medications/delivery methods (Inhaler/Epi-pen/Insulin, etc.) _____

3) **Asthma:**
Is medication necessary prior to activity?
(eg., playground play) Yes No

What is your child’s best peak flow?

What peak flow meter do you use at home?

Diabetes:
At what times/intervals does your child check
blood sugar levels? _____

What is your child’s insulin dose? _____

Time(s) your child receives insulin injections:

4) Additional information/concerns: _____

Bright Lights encourages pro-active, self-management of health conditions by students who are capable of self-administration. In addition, Bright Lights strongly advises parents/guardians to send a second “back up” inhaler to keep in the Bright Lights health office at Randolph Elementary School while the child is on premises.

Please check all of the following which apply:

1) *My child is capable of self-administration. S/he will: 1) carry the Inhaler Epi-pen Insulin on his/her person
**Only students at 6th grade and above may self-administer Epi-pens and insulin injections. Students 5th grade and below must check medications in with designated BL staff.*

*(Parent/guardian must sign **Section A** on attached Medical Release Form)*

2) keep the Inhaler Epi-pen Insulin in his/her classroom
3) bring a “back up” Inhaler Epi-pen on the first day of class and check it in with the Health Nurse who will store it for the week.

2) My child is **not** capable of self administration and needs assistance. We will check his/her medication/delivery device with the Health Nurse at Randolph Elementary. She will store it for the week and administer the medication per physician’s authorization.

*(Parent/guardian must sign **Section B** on Attached Medical Release Form)*

3) I will not be sending medication/delivery device with my child or checking it with the Health Nurse during Bright Lights’ summer program.

*(Parent/Guardian must sign **Section C** on attached Medical Release Form)*

X _____ **Date** _____
(Parent/Legal Guardian Signature-Required)

Return by: _____ To: Bright Lights, Inc., 5561 S 48th Street, Suite 220, Lincoln, NE 68516

MEDICAL RELEASE FORM

**** Important: No health support is available at locations other than our main program site, Randolph Elementary School.**

All parents must complete, sign and return this Medical Release Form. (Sign Section A, B or C.)

Bright Lights requires physician authorization PRIOR to medication administration (by self-administering student or Bright Lights personnel). Physician authorization is evidenced by:

- 1) Medication presented to designated Bright Lights staff member in original packaging with pharmacy label intact. **See specific requirements on reverse.*
(Parent/guardian must sign **Section A** if child is self-administering or carrying meds/supplies.)
- OR◄**
- 2) ****Physician's signed and dated authorization on the Statement of Authorization below.**

Check one box above, indicating which method of physician authorization you are supplying.

SECTION A

IMPORTANT: If your child is self-administering and/or carrying an Inhaler, Epi-pen, Insulin, etc., a parent/guardian must sign this Statement of Authorization. A physician's signature is required ONLY if you checked #2 above.

STATEMENT OF AUTHORIZATION

_____ has been instructed in the proper use of: *Please check:* Inhaler
(Child's full name) Epi-pen
 Insulin/Glucose

I, _____, request that _____ be permitted to carry: Inhaler
(Parent/Legal Guardian) (Child's Full Name) Epi-pen
 Insulin/Glucose

on his/her person or to keep same in his/her classroom, as we consider him/her responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of use of his/her inhaler, Epi-pen or diabetic equipment.

Medication may be self-provided by the child, and the child is competent to self-provide medication. We, child and parent (under the advisement of my child's physician) have developed a plan for self provision of the medicine, storage of medicine, and a plan for reporting that is deemed safe and appropriate. **Student agrees to notify the Bright Lights staff immediately when experiencing any difficulty with his/her medical condition/health management.**

I, the undersigned parent/guardian, absolve Bright Lights, Inc. and its employees, agents, representatives and officers of any responsibility in safeguarding my child's inhaler, Epi-pen or diabetic equipment. I accept ultimate responsibility for monitoring the effects of this medication.

X _____ Date _____
(Parent/Legal Guardian Signature-Required)

I, the undersigned treating physician, agree with and become party to this Statement of Authorization:

X _____ Date _____

(**Physician's Signature-required only if you checked #2 above as evidence of physician authorization.)

(CONTINUED ON REVERSE)

SECTION B

My child **is not** capable of self-administration of his/her medication. I will supply the originally packaged medication with intact pharmacy label (*showing required information listed below) to the Bright Lights Health Nurse at the main program site, Randolph Elementary School, on the first day of class. I understand that Bright Lights will store the medication for the week while my child is on premises, and it is my responsibility to pick up the medication on the last day of class (Friday).

Note: If your child is attending an off-site class, you are responsible for making arrangements with the designated Bright Lights staff person regarding your child's care. (See list below.)

My child agrees to notify the Bright Lights staff immediately when experiencing any difficulty with his/her medical condition/health management.

X _____ Date _____
(Parent/Legal Guardian Signature-Required)

SECTION C

I acknowledge that Bright Lights has been pro-active in encouraging me to send the appropriate medication for my child's safety while attending the Bright Lights summer program. My signature below evidences my consent to NOT send such medication with my child or supply it to the designated Bright Lights staff member. I understand that emergency protocol will be followed and 911 will be called in the event my child experiences a life-threatening medical emergency. **My child agrees to notify the Bright Lights staff immediately if experiencing any difficulty with his/her medical condition.**

X _____ Date _____
(Parent/Legal Guardian Signature-Required)

*Medication must be checked in with the designated Bright Lights staff member on the first day of class (*see below*). Medication must be in original pharmacy or manufacturer's packaging with pharmacy label intact. A prescription label, properly dated and indicating the name of student, name of medication, instruction with dose of medication to be administered, name of prescriber and time of medication administration. (*Any discrepancy, or change, between parent/guardian written consent and the prescription label must be rectified by written authorization from the prescriber stating the corrected or updated information corresponding to the parent/guardian written consent.*)

Designated staff members are as follows:

Main Program Site: Randolph Elementary School: Rita McClure, LPN
Lux Middle School: Barb Highstreet, Building Coordinator
Community Site Classrooms: Class Teacher

Epi-pen: If an Epi-pen is administered, 911 will be called.

Inhaler: Parent/legal guardian, **bring a back-up inhaler** on the first day of class and check it in with the Bright Lights Health Tech who will store it for the week in the health office. Bring the inhaler in the original container labeled with the student's name, instructions, with dosage, current date, time to be administered and physician's name. On Friday, parent/legal guardian is responsible for picking up the back-up inhaler.