FVSRA

Fox Valley Special Recreation Association

2024 Summer Day Camp Registration Packet

2024
Summer Day Camp Registration Packet

- Day Camp Registration Form (Available Online!)
- Registration Waiver
- Scholarship Application
- 2024-25 Annual Information Form (Available Online!)
- Seizure Information Form (Available Online!)
- Participant Lift/Transfer Form
- Permission to Dispense Medication Form

Questions?
Contact Michelle Hastings, Day Camp Manager
MichelleH@fvsra,org
Office Phone: 630-907-1114 Ext. 1212
Mobile: (630) 770-4717

SUMMER DAY CAMP REGISTRATION FORM

June 2024 - July 2024

Save Time- Online Registration Available! Visit www.fvsra.org/summer-day-camp

Participant Name: _____

T-Shirt Size:

☐ Adult	☐ Sm	☐ Med	☐ Lg	☐ Xlg	☐ 2XL	☐ 3XL	☐ 4XL
☐ Youth	☐ Sm	☐ Med	☐ Lg				

Transportation Accommodations: **Does your child utilize any special accommodations or equipment while using school transportation due to physical, emotional, or behavioral needs that would be helpful during transportation during camp?** ☐ **Yes** ☐ **No**

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Step 1:

☑ **Check Camp Choice:**

NORTH CAMPS
South Elgin, St. Charles, Geneva, & Batavia

- ☐ **Camp Rising Stars** — Alice Gustafson Elementary, Batavia — Ages 5-10
- ☐ **Camp All Stars** — Rotolo Middle School, Batavia — Ages 11-16
- ☐ **Camp Rock Stars** — Rotolo Middle School, Batavia — Ages 17-22

SOUTH CAMPS
Aurora, Sugar Grove, Montgomery, & Oswego

- ☐ **Camp Rising Stars** — McDole Elementary, Montgomery — Ages 5-10
- ☐ **Camp All Stars** — Thompson Jr. High, Oswego — Ages 11-16
- ☐ **Camp Rock Stars** — Traughber Junior High, Oswego — Ages 17-22

Step 2:

☑ **Check Week(s):**

Campers must register at least 10 business days prior to starting camp

☑ Check Week(s)	Camp Week	Resident Fees	Non-Resident Fees
	All 6 Weeks (June 10 - July 25)	$1,080	$1,350
	Week 1 (June 10 - June 13)	$192	$240
	Week 2 (June 17, 18 & 20)	$144	$180
	Week 3 (June 24 - June 27)	$192	$240
No Camp Week of July 1-3 Check out our Mid-Summer Mini Camp Option in our Summer Brochure			
	Week 4 (July 8 - July 11)	$192	$240
	Week 5 (July 15 - July 18)	$192	$240
	Week 6 (July 22- July 25)	$192	$240
No Camp Week of July 29-August 1 Check out our Last Blast Mini Camp Option in our Summer Brochure			
	TOTAL		

If you would like to request financial assistance or a payment plan please contact the office at 630-907-1114 or info@fvsra.org. **If requesting a scholarship, a paper registration must be completed (online registration not accepted).**

Note: When registering by FAX, it is mutually understood that the facsimile registration document (including the waiver & release of all claims) shall substitute for, and have the same legal effect, as the original form.

FVSRA Card Payment Notice
Beginning March 20, 2024, a small 3.25% credit card processing fee will be applied to transactions, aimed at covering the costs associated with credit card processing. Read the full notice on this change on our website, at fvsra.org/summer-day-camp.

FOR OFFICE USE ONLY

DATE _____

CHECK # _____

AMOUNT DUE _____

SCHOLARSHIP _____

Step 4:

Waiver (see next page)

Registration Waiver

Fox Valley Special Recreation Association

2121 W. Indian Trail, Aurora, IL 60506
P: (630) 907-1114 • F: (630) 907-1116 • W: FVSRA.org

Important Information

The Fox Valley Special Recreation Association (FVSRA) is committed to conducting its recreation programs and activities in a safe manner and holds the safety of participants in high regard. The FVSRA continually strives to reduce such risks and insists that all participants follow safety rules and instructions that are designed to protect the participants' safety. However, participants and parents/guardians of minors registering for this program/activity must recognize that there is an inherent risk of injury when choosing to participate in recreational activities.

You are solely responsible for determining if you or your minor child/ward are physically fit and/or skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way, or recently suffered an illness, injury, or impairment, to consult a physician before undertaking any physical activity.

Warning of Risk

Recreational activities/programs are intended to challenge and engage the physical, mental, and emotional resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning, and equipment, there is still a risk of serious injury when participating in any recreational activity/program. All hazards and dangers cannot be foreseen. Depending on the particular activity, certain risks, dangers and injuries may exist due to inclement weather, slips and falls, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instructive or officiating, and other risks inherent to the particular activity. IN this regard, it is impossible for FVSRA to guarantee absolute safety.

Waiver and Release of All Claims and Assumption of Risk

Please read this form carefully and be aware that in signing it and participating in FVSRA activities, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or losses which you or your minor child/ward might sustain as a result of participating in any and all activities connected with and associated with this program/ activity (including transportation services/vehicle operation, when provided).

I recognize and acknowledge that there are certain risks of physical injury to participants in this program/activity, and I voluntarily agree to assume that full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of participating in this program/activity against the FVSRA, including its officials, agents, volunteers and employees (hereinafter collectively referred as "FVSRA").

I understand the FVSRA may photograph/videotape the events or activity in which I am (or my child/ward is) participating. I give my permission for the FVSRA to use photographs or videotape of me (or my child/ward) for the purpose of promoting the FVSRA and its services/programs. I give my permission with the following understanding: No compensation of any kind will be paid to me (or my child/ward) at this time or in the future for the use of my (or my child/ward's) likeness.

In the event of an emergency, I understand and authorize FVSRA staff and officials to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for immediate care for myself or minor child/ward and agree that I will be responsible for payment of any and all medical services rendered.

I have read and fully understand the above Important Information, Warning of Risk, Waiver, Assumption of Risk, and Release of All Claim. If registering a minor participant, I further attest that

I have read the above to my minor child/ward. If registering by fax, your facsimile signature shall substitute for and have the same legal effect as an original form signature.

NOTE: When registering by FAX, it is mutually understood that the facsimile registration document (including the Waiver & Release of All Claims) shall substitute for, and have the same legal effect, as the original form.

REQUIRED *Sign & Date*

Participant's Name (Print): _____ Date: _____

Participant's Signature: _____

18 years or older or Parent/Guardian

Participation will be denied if the signature of adult participant or parent guardian is not on this waiver.

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Fox Valley Special Recreation Association

Scholarship Application

Valid March 1, 2024 through April 30, 2025

The APPLICANT is the person responsible for paying the costs of the programs. Note: If participant is 19 years or older, they will be considered for scholarship eligibility based on their own information. The applicant is: (check one)

☐ Participant/Self ☐ Guardian 1 ☐ Guardian 2 ☐ Other (please specify) _____

Participant Information

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____

Guardian Information (if Participant is Under Age 19 or enrolling in Summer Day Camp)

	Guardian 1	Guardian 2
Name:		
Address:		
City, State, Zip:		
Phone:		
Marital Status:		

Please check if you currently receive one of the following authorized documents (MUST PROVIDE DOCUMENTATION):

_____ Social Security Income (SSI)
_____ Supplemental Nutrition Assistance Program (SNAP) through IL Link
_____ Illinois All Kids (CHIPRA)
_____ YouthCare Health Plan, DCFS

If you have checked one of the above and have appropriate documentation, the application is complete. If not, please complete page two.

Office Use Only:

Percent Awarded: _____ Amount Awarded: _____

Staff Initials: _____ Date: _____

2121 West Indian Trail
Aurora, IL 60506
(630) 907-1114 phone (630) 907-1116 fax

STOP: ONLY FILL OUT THIS PAGE IF YOU DID NOT SELECT ANY OF THE 4 AUTHORIZED DOCUMENTS ON PAGE 1

Fill out the form below. Please provide as much documentation as possible. The Scholarship Committee reviews all scholarship applications and has the right to request additional documentation and also reserves the right to deny applications based on incomplete information.

Monthly Income			
Please list all forms of income	Participant	Guardian 1	Guardian 2
Wages: (please provide W-2)			
Other: (i.e.: Child Support)			
Other:			
Monthly Total:			
Total Annual Income:			

Monthly Expenses			
	Participant	Guardian 1	Guardian 2
Mortgage/Rent:			
Utilities:			
Loans:			
Medical:			
Medical Insurance:			
Auto Insurance:			
Food:			
Other: (please list)			
Monthly Total:			
Total Annual Expenses:			

Please describe any unusual circumstances the participant and/or their family may be experiencing with regard to finances that should be considered in the review of the scholarship application:

All information provided will be kept confidential and is not subject to the Freedom of Information Act. All information is requested as incomplete applications may not be considered.

Applicant's Signature: _____ Date: _____

Relationship to Participant: _____

2121 West Indian Trail
Aurora, IL 60506
(630) 907-1114 phone (630) 907-1116 fax

ANNUAL INFORMATION FORM

Valid March 1, 2024 - May 31, 2025

PARTICIPANT INFORMATION

Participant Last Name _____ **Legal First** _____ **Preferred First** _____
Address _____ **City** _____ **Zip** _____
Residency Type ☐ With Family ☐ Group Home ☐ Independent **Shoe Size** _____
Park District _____ **Township** _____ **T-Shirt Size** _____
Gender _____ **Personal Pronoun** ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____
Age _____ **Birthdate** _____ **Ethnicity (for statistical purposes only)** _____

PARENT/GUARDIAN INFORMATION

Main Contact _____
Relationship _____
Cell Phone _____
Mobile Carrier _____
Home Phone _____
Email _____
Employer _____

Secondary Contact _____
Relationship _____
Cell Phone _____
Mobile Carrier _____
Home Phone _____
Email _____
Employer _____

Participant is own guardian?
☐ No ☐ Yes

Who should FVSRA contact for program information?
_____
_____

For individuals who live in a group home / residential facility

Residential Facility _____ **Case Manager** _____ **Email** _____
Phone _____ **Weekend/Emergency Number** _____

MEDICAL INFORMATION

Disability / Diagnosis Information: Please indicate primary disability with a "1" and secondary disability with a "2."

☐ ADHD
☐ Autism Spectrum Disorder
☐ Behavioral Disorder
☐ Cerebral Palsy
☐ Down Syndrome
☐ Hearing Impairment
☐ Intellectual Disability
☐ Learning Disability
☐ Mental Illness
☐ Physical Disability
☐ Seizure Disorder/Epilepsy
☐ Speech/Language Disorder
☐ Traumatic Brain Injury
☐ Visual Impairment
☐ Other _____

If the participant has Down Syndrome, do they have an Atlanto-Axial Instability diagnosis? ☐ No ☐ Yes ☐ N/A

Medical Conditions / Needs

Seizures ☐ No ☐ Yes (if yes, a Seizure Information Form must be completed)
Shunts ☐ No ☐ Yes (if yes, please describe) _____
G-Tube / J-Tube ☐ No ☐ Yes (if yes, a G-Tube / J-Tube Support Plan must be completed)
Wheelchair ☐ No ☐ Yes (if yes, a Participant Transfer Plan must be completed)
Diabetes ☐ No ☐ Yes (if yes, a Diabetes Management Plan must be completed)
Diabetes Management ☐ N/A ☐ Manages diabetes independently ☐ Does **not** manage diabetes independently
Allergies ☐ No ☐ Yes (if yes, please describe) _____
Allergies Management ☐ N/A ☐ Epi-Pen intervention required (if checked, a Permission to Dispense Medication must be completed)
Dietary Needs ☐ No ☐ Yes (if yes, please describe) _____
Alcohol Consumption (21+) ☐ No ☐ Yes (if yes, please describe type and quantity permitted. Note FVSRA has a two drink maximum)
_____

COMMUNICATION

Select all that apply

☐ Verbal: Easy to Understand
☐ Verbal: Difficult to Understand
☐ Deaf/Hard of Hearing
☐ Non-Verbal
☐ Non-Verbal: Gestures / Modified Sign Language
☐ Echolalia
☐ English is a second language. Primary Language: _____
☐ Communication Board (Boardmaker)
☐ iPad or tablet
☐ Heading Aid
☐ Cochlear Implant
☐ Sign Language Interpreter
☐ Symbol-based Augmentative & Alternative Communication
☐ Other _____

PHYSICAL / ASSISTED DEVICES

Select the level of assistance that is needed:

	Independent	Verbal Prompts	Physical Assistance	Additional Information
Eating/Drinking (cut food, uses straw, etc.)	☐	☐	☐	_____
Dressing/Undressing (tying shoes, pulling up swim suit, etc.)	☐	☐	☐	_____
Toileting (Diapers, catheter, wiping, etc.)	☐	☐	☐	_____
Following directions (single step, repetition, visual cues, etc.)	☐	☐	☐	_____
Money Handling (monitor for correct change, no concept, etc.)	☐	☐	☐	_____
Reading (comprehension level, etc.)	☐	☐	☐	_____
Responsibility (keeping track of belongings, etc.)	☐	☐	☐	_____
Writing (legibility, words/sentences, etc.)	☐	☐	☐	_____

What assisted devices are used (select all that apply):

☐ Cane
☐ Forearm Crutches
☐ Glasses
☐ Orthopedic Devices
☐ Prosthetic Devices
☐ Service Animal
☐ Walker
☐ White Cane
☐ Wheelchair- Electric
☐ Wheelchair- Manual
☐ Wheelchair- For long distances only
☐ Other _____

BEHAVIOR

Select all behaviors that occur frequently (once or more per week):

Physical Outbursts
- ☐ Biting Others
- ☐ Hair Pulling
- ☐ Hitting Others
- ☐ Kicking Others
- ☐ Scratching Others
- ☐ Shoving Others
- ☐ Spitting

Repetitive Behaviors
- ☐ Biting Self
- ☐ Headbanging / Hitting Self
- ☐ Picking Skin
- ☐ Pulling I lair
- ☐ Putting Objects in Mouth

Destructive Behaviors
- ☐ Throwing Objects
- ☐ Destroying Objects

Verbal Outbursts
- ☐ Foul Language
- ☐ Threats to Harm Others
- ☐ Threats to Harm Self

Emotional Outbursts
- ☐ Crying
- ☐ Tantrum
- ☐ Meltdown

Non-Compliance
- ☐ Refusal to Participate
- ☐ Refusal to Transition
- ☐ Defiance to Directions

Elopement Behaviors
- ☐ Wander / Leave Group
- ☐ Runs Away / Flight Risk

Other
- ☐ Removal of Clothing
- ☐ Stealing Belongings
- ☐ Stealing Food
- ☐ Other _____

Has a formal behavior plan been created?

☐ No ☐ Yes (please attach)

Additional Information on behaviors (frequency, duration, triggers etc.)

How can staff best support and respond during behaviors (coping strategies, calm down techniques, sensory supports, etc.)

SAFETY AND RECREATION

FVSRA provides an approximate 1:4 staff to participant ratio. If you would like to request a closer ratio, please explain why:

The participant CANNOT recognize the following dangerous situations:

☐ Crossing the street ☐ Kitchen Safety ☐ Unwanted physical attention
☐ Sharp objects ☐ Water Safety ☐ Other _____

Can the participant readily communicate their name? ☐ No ☐ Yes

Can the participant accurately communicate their phone number? ☐ No ☐ Yes

Select the statement that best indicates swimming ability:

- ☐ Cannot Swim
- ☐ Can swim 1 length of the pool without a personal flotation device
- ☐ Needs 1:1 assistance in the water
- ☐ Competitive / Multi-lap Independent Swimmer

Indicate flotation device(s) owned or needed to swim: _____

In accordance with our Pick-Up & Drop Off Policy, Participants are expected to arrive and/or be picked up from a program within 5 minutes of the start and end times listed. Without prior written approval, FVSRA cannot leave participants unattended before or after a program and a fee may be issued. FVSRA requires prior written approval to permit a participant to remain unattended before/after a program, walk home, or wait for a taxi service. Contact Superintendent of Recreation to submit requests.

GOALS

Indicate the reason(s) for participation in FVSRA programs (select all that apply):

- ☐ Creativity / Self-Expression
- ☐ Physical Activity / Fitness
- ☐ Skill Development
- ☐ Self-Esteem / Confidence
- ☐ Responsibility
- ☐ Socialization / Friendship
- ☐ Entertainment / Fun

REQUIRED

I attest that this information is true and accurate to the best of my knowledge and I will notify FVSRA of any changes in the above information.

_____ _____

Signature of person completing form **Date**

SEIZURE INFORMATION FORM

Valid March 1, 2024 - May 31, 2025

Participants with a history of seizure must complete this form and return a signed copy of a seizure plan from their doctor if applicable. This form should be updated whenever there are changes to the seizure plan, medications, etc., and on an annual basis .

PARTICIPANT INFORMATION

Participant Name _____ **Birthdate** _____

Parent/Guardian Name _____ **Emergency Contact Name** _____

Cell Phone _____ **Cell Phone** _____

Home Phone _____ **Home Phone** _____

SEIZURE INFORMATION

Has the participant ever had a seizure? ☐ No ■ Yes

Does the participant have a Seizure Plan created by a medical professional? If yes, please email a copy of the plan to info@fvsra.org ☐ No ☐ Yes

What type of seizures does the participant have? (Check all that apply)

☐ Complex Partial Seizure ☐ Drop Seizure ☐ Grand Mal / Generalized Tonic-Clonic Seizure

☐ Simple Partial Seizure ☐ Myoclonic Seizure ☐ Petit Mal / Absence Seizure

☐ Unknown ☐ Other _____

Please provide a description of the seizure:

_____

_____

Are there any symptoms, triggers, and/or auras prior to the onset of the seizure? ☐ No ☐ Yes
If yes, please describe.

_____

_____

How frequently do seizures occur?

☐ Daily

☐ Weekly

☐ Monthly

☐ 1 - 6 times per year

☐ No seizures in a year or more

What was the duration of the participant's longest seizure?

☐ Less than 1:00 minute

☐ 1:00 - 1:59 minutes

☐ 2:00 - 2:59 minutes

☐ 3:00 - 3:59 minutes

☐ 4:00 - 4:59 minutes

☐ 5:00 - 10:00 minutes

☐ 10:00 - 30:00 minutes

☐ Longer than 30 minutes

Describe the participant's typical post-seizure condition (lethargic, confused, etc.)

_____

_____

Does the participant have a Vagal Nerve Stimulator (VNS)? If yes, describe instructions for appropriate magnet use and if the magnet will be passed on to Program Leader for use during programs. If the magnet is no longer used as an intervention, write N/A. ☐ No ☐ Yes

_____

_____

List any emergency medication to be used during and/or following a seizure (include medication name, dosage, and possible side effects).
NOTE: FVSRA will call 911 at onset of perceived seizure for anyone who utilizes emergency medication for seizures. FVSRA cannot administer rectal or injectable medication and cannot administer any emergency nasal or oral medication during the seizure (e.g. Diastat, Nasal Versed, Lorazepam). Upon request, FVSRA will hold and pass these medications to EMS/hospital staff in the case of an emergency.

_____

SEIZURE RESPONSE PLAN

FVSRA policy is to call 911 after 3 minutes of perceived continuous seizure activity (or sooner if staff determine necessary). If you would prefer Emergency Medical Services (EMS) called at the initial perceived onset of the seizure, check "Yes." ☐ No ☐ Yes

List any additional steps you would like taken in the event of an emergency. If not applicable, type N/A

_____

Name of person completing this form _____ **Signature** _____

Relationship to Participant _____ **Date** _____

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Fox Valley Special Recreation Association

Participant Support and Transfer Request for Accommodation

Participant _____ Weight (lbs.) _____ Date _____

Participant Care and Transfers

FVSRA requires participants/guardians to complete a Participant Care and Transfer Request for Accommodation for any participant who utilizes a wheelchair or who needs physical assistance standing, sitting, or walking beyond verbal prompts. This form needs to be updated whenever there is a change in participants' needs and/or at time of registration. FVSRA will review the information listed below to create a transfer plan. The participant/guardian will need to sign off on the final care and transfer plan. Email to info@FVSRA.org or submit to FVSRA front desk.

Assistive Devices: Select assistive device(s) utilized by participant. (Check all that apply)

▫ Manual wheelchair ▫ Electric wheelchair ▫ Walker ▫ White cane ▫ Cane

▫ Other/Details:_____

Care and Transfer: Select situations when physical support is requested. (Check all that apply)

▫ Support in/out chair ▫ Transfer to toilet ▫ Transfer to pool deck/chair ▫ Transfer to changing table

▫ Support/Guide when walking ▫ Other/Details:_____

Wheelchair Specific: If applicable, please select from the following:

▫ Self operates ▫ Requires staff assistance to maneuver

If a wheelchair is only used in specific circumstances (long walks, full-day programs, etc.) please provide additional information:

_____

Can the participant bear weight? ▫ Yes ▫ No ▫ Partially

Does participant use a transfer aid (slide board, gait belt, etc.)? ▫ Yes ▫ No

If yes, what transfer aid is utilized and how:

_____

Please share any circumstances when the participant requests to be removed from wheelchair. (Alternative seating-cube chair, pressure breaks, adapted swing, etc.)

_____

Transportation:

FVSRA staff cannot provide significant physical assistance as participants enter or exit the bus. Participants who need physical assistance must utilize the wheelchair lift enter/exit the bus. All wheelchairs must have wheelchair tie-down hooks if the participant will remain in their wheelchair during transport.

Does participant....

Need to utilize the vehicle lift? ▫ Yes ▫ No (may use the stairs independently)

Need to be transferred to a bus seat once on bus? ▫ Yes ▫ No (if yes, explain below)

_____

Transfer Plan Details

Please list all steps necessary to transfer participant for FVSRA review. FVSRA reserves the right to approve all, some, or none of the steps listed below to comply with FVSRA procedures.

_____

_____

_____

_____ _____ _____

Guardian Name Guardian Signature Date

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Fox Valley Special Recreation Association

Permission to Dispense Medication

Waiver and Release of All Claims

Fox Valley Special Recreation Association (FVSRA) will not dispense medication to a minor child or adult participant without a completed Permission and Waiver to Dispense Medication and Medication Information Form. Requests to administer medication are assessed on an individual basis, and each request is reviewed before the start of a program. FVSRA will contact you if your request to dispense medication cannot be honored. The agency's internal procedures on dispensing medication are available for review upon request.

FVSRA cannot accept medication that is not individually packaged in medication envelopes.

You must complete this form for each program that medication must be dispensed at and/or when medication changes.

Program Name	Program Date(s):

I, _____ (Print Name), the Parent/Guardian of _____ (Print Participant Name),
give permission to the staff of Fox Valley Special Recreation Association to administer to my child or adult the medications as indicated on page 2 of this form.

I understand it is my responsibility to give the medication directly to the program staff in individual dosage envelopes, which include the person's name, medication, dosage, and time of day the medication is to be dispensed. Envelopes should be sealed and NOT clear. If mediation is liquid or needs to be refrigerated, it may stay in the original bottle with proper dosing equipment (syringe).

In all cases, the recommended dosage of any medication will not be exceeded. If an adverse reaction occures after administering the medication, I give my permission to Fox Valley Special Recreation Association to secure from any licensed hospital physician and/or medical personnel any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child/adult participant. In consideration of the Fox Valley Special Recreation Association administering medication to my minor child/adult participant, I do hereby fully release or discharge the Fox Valley Special Recreation Association and its officers, agents, volunteers, and employees from any and all claims from injuries, damages, and losses. I or my minor child/adult participant may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless, and defend the Fox Valley Special Recreation Association and its officers, agents, volunteers, and employees from any and all claims resulting from injuries, damages, and losses sustained by me or my minor child/adult participant arising out of, connected with, incidental to, or in any way associated with the administering of medication.

_____ Guardian Signature

_____ Date (MM/DD/YYYY)

Permission to Dispense Medication

FVSRA
Fox Valley Special Recreation Association

This form must be completed for <u>each</u> program that medication must be dispensed at and/or when medication changes.

Participant Name: ______________________________

Doctor's Name: ______________________ **Doctor's Phone:** ______________

Administration Type: ☐ Self Administered ☐ Staff Administered

Responsibility to Store Medication: ☐ Individual ☐ Staff

FVSRA cannot accept medication that is not individually packaged in the medication envelopes (available at the FVSRA office). Medication envelopes MUST contain the following:

1) Participant's Name 2) Mediation Name 3) Dosage 4) Date to Dispense 5) Time to Dispense

Medication Information

Medication Name	
Dose	
Time(s)	
Possible Side Effects	
How is this medication taken?	☐Whole ☐With Food ☐Without Food ☐Chewed ☐With Water ☐Without Water
Dispensing & Storing Instruction	

Medication Name	
Dose	
Time(s)	
Possible Side Effects	
How is this medication taken?	☐Whole ☐With Food ☐Without Food ☐Chewed ☐With Water ☐Without Water
Dispensing & Storing Instruction	

Medication Name	
Dose	
Time(s)	
Possible Side Effects	
How is this medication taken?	☐Whole ☐With Food ☐Without Food ☐Chewed ☐With Water ☐Without Water
Dispensing & Storing Instruction	

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency in writing if any changes in the dispensing of medication occur.

______________________________ ______________

Guardian Signature Date (MM/DD/YYYY)

<u>Updated 12/08/2023 by JJ</u>

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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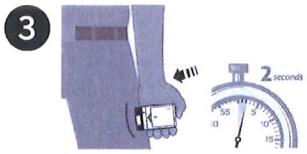
FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

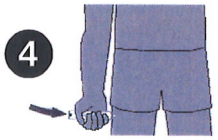
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



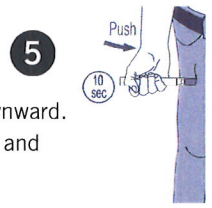
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



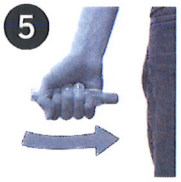
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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