stepping stones

An Early Childhood Learning Center

SUMMER CAMP REGISTRATION FORM 2024

245 86th Street, Brooklyn, NY 11209

247 86th Street, Brooklyn, NY 11209

9321 Ridge Blvd Brooklyn, NY 11209

Child's Name (last)_____ (first) _____DOB ___/___/____

Home Address _____ City _____State _____ Zip_____

Phone Number _____ Email: _____ Male □ Female □

Additional children attending camp:

Child's Name (last)_____ (first) _____DOB ___/___/____

SIX WEEK SESSION ONLY – July 1st - August 13th (CLOSED July 4th & July 5th)

PLEASE SELECT THE GROUP: **Hours of Operation: 7:00am-3:30pm**

□ **TODDLER GROUP –**Born 2022 (Must be 2 by June 30, 2024) **Full day** 8:00am-3:00pm **Half Day** 8:00am-11:00am

□ **EXPLORER GROUP –** Born 2021 **Full Day** 8:00am-3:00pm **Half Day** 8:00am-11:00am

□ **PRESCHOOLER GROUP -**Born 2020 **Full Day** 8:15am-3:15pm **Half Day** 8:15am-11:15am

□ **JUNIOR GROUP -**Born 2018 to 2019 **Full Day** 8:15am-3:15pm **Half Day** 8:15am-11:15am

□ **SENIOR GROUP –** Born 2014 to 2017 **Full Day** 8:15am-3:15pm **Half Day** 8:15am-11:15am

□ **PRESCHOOLERS GROUP –** Born 2020 **(Tentative 94th Street)** **Full Day** 8:15am-3:15pm **Half Day** 8:15am-11:15am

Please circle this group if you are interested in the 94th Street location. This will open based upon enrollment.

	Days of the Week	Scheduled Time	Summer Tuition	Extended Morning 7am drop off	Please choose the program and write each child's name next to the schedule chosen.
	Five Days a Week Mon, Tues, Wed, Thurs, Fri	FULL DAY	$3625	$200	
	Three Days a Week Mon, Wed, Fri	FULL DAY	$2900	$150	
	Two Days a Week Tues, Thurs	FULL DAY	$2300	$100	
	Five Days a Week Mon, Tues, Wed, Thurs, Fri	HALF DAY	$2450	$200	
	Three Days a Week Mon, Wed, Fri	HALF DAY	$2000	$150	
	Two Days a Week Tues, Thurs	HALF DAY	$1650	$100	

Non-Refundable Deposit required to register $300

NO REGISTRATION FEE- DEPOSIT ONLY

Summer Tuition Total $_____

Balance Due May 1st (deduct deposit of $300) $_____

If you are registering more than one child, a sibling discount of 5% will be applied to each additional child's tuition of equal or lesser value.

- *Trip fees are not included. (Trips to be determined closer to summer. Will receive trip slip with fee.*

Toddlers and Explorers do not need to be potty trained to attend camp.

*All new student immunizations must be completed on a physical examination.
Camper cannot begin unless a form is submitted with up-to-date immunizations.

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CHILD INFORMATION REGISTRATION FORM 2024

Child's Name (last): _____ (first): _____ Date of Birth____/____/____ Male □ Female □

Home Address _____ City _____ State_____ Zip Code_____

Child lives with: _____ Number of Siblings: _____ Names and Ages: _____

Legal Guardians are □ Unmarried □ Married □ Separated □ Divorced □ Other _____

Parent/Guardian 1 □Mother □Father □Other	**Parent/Guardian 2 □Mother □Father □Other**
First & Last Name	First & Last Name
Address *(if different)*	Address *(if different)*
Home Phone #	Home Phone #
Work Phone #	Work Phone #
Mobile Phone #	Mobile Phone #
Email	Email
Occupation	Occupation
Employment Address	Employment Address

Additional Information:

Child Physician Name/Contact Number: _____ _____ _____ Medical Conditions, allergies (Explain): _____ _____ Life-threatening allergies □ No □Yes (explain) _____ Epi Pen □Yes □ No Receiving Special Services: □Speech/Language □Occupational □Physical Therapy □SEIT □Special Instruction For how many months? _____	Primary Emergency Contact (other than Parent/Guardian): Name_____ Relationship to child:_____Phone:_____ Name_____ Relationship to child:_____Phone:_____ Name_____ Relationship to child:_____Phone:_____

Any additional information you would like to tell us about your child: _____

_____

_____

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SUMMER CAMP 2024 AGREEMENT CONTRACT

Name of Child #1: _____ DOB: _____
Name of Child #2: _____DOB: _____

Legal Guardian/Parent Name 1: _____
Legal Guardian/Parent Name 2: _____

Communication between Parent/Teacher/Stepping Stones

- The Parent acknowledges that they received the current copy of the Summer Camp Policy Book and will comply with all the terms and conditions of the program.

Program Fees/Withdrawals:

- At the signing of this contract, the parents agree to pay an initial $300 non-refundable deposit fee per child. For Summer 2024, this deposit will be deducted from the total camp tuition. The summer camp tuition balance is to be paid in full by May 1st. A late fee of $20 per day will be charged. If the payment, including late charges is not received by May 5th, Stepping Stones will terminate the Summer Camp Agreement and enrollment of the child(ren).
- Summer Camp tuition will not be returned, refunded or credited due to absence (related or non-related to Covid-19), child quarantine, classroom quarantine, any illnesses, late arrival, late registration, vacations, withdrawal from the program, mandatory government agency shutdown, Department of Health closures, natural disaster and/or any emergency camp closures once camp has begun.
- Last date to withdraw will be May 1st for a summer tuition refund. The $300 deposit is non-refundable.
- If you would like to change your child's summer camp schedule you may be permitted to do so if there is space available in that program. Policies and refunds will not be changed if there is no availability.
- The parent understands that Stepping Stones may terminate any child's enrollment for any reason but not limited to incomplete immunization compliance, past due tuition payments or behaviors that may pose a threat to the well-being of any children, staff, etc.

Late Pick-up and Early Drop-Off Policy and Fees:

- Summer Camp 2024 will not have any extended hours after 3:30pm.
- There will be a late fee applied for all pick ups after 3:30pm.

SUMMER CAMP 2024 AGREEMENT CONTRACT Continued

Name of Child #1: _____ DOB: _____

Name of Child #2: _____ DOB: _____

Accepted Payment Method Terms and Policy

- Check, Cash, Money Order, ACH (Automatic Deduction from bank), Brightwheel app (Includes Master Card, Visa and Debit options). Please note there may be additional fees charged by Brightwheel depending on the card used.
- Return check or non-payment due to insufficient funds will incur a charge of $30. Nonpayment of returned funds may result in the removal of child(ren) from Stepping Stones and the pursuit of legal remedies for unpaid balances.

Medical Release:

- The parent/s understand that the child must be fully immunized with a completed yearly physical examination form to attend Stepping Stones according to the Department of Health mandated immunizations.
- The parent/s of the above-named child, do hereby authorize and consent the directors, teachers and employees of Stepping Stones to contact the persons named on this form, and to authorize the named physician or his/her associates to render such treatment as may be deemed necessary in an emergency medical treatment for the health of my child.
- The parent/s understand that every effort will be made to notify me immediately in case of such an emergency. In the event the parents or other persons named on this form cannot be reached, the parent consents the directors, and/or teachers and employees to take whatever action is deemed necessary in the judgment for the health of my child. The parent agrees to be completely responsible for all medical expenses, payments of debts, or bills incurred with the injury or any illness of my child.

The Parent has seen and read the Summer Camp Parent Book and herein agrees to abide and comply by all the policies and procedures contained in the book.

THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS AGREEMENT, and by signing this Agreement, all parties agree to all of the above terms, conditions and policies, including financial responsibilities for child care provided. The Provider is responsible for providing all parties a copy of this signed Agreement.

Legal Guardian/Parent Name:(print) _____Signature_____

Legal Guardian/Parent Name:(print) _____Signature_____

Date: _____

The Office at Stepping Stones

Email: office@steppingstones86.com

- **stepping stones nursery school • 245 86th street • brooklyn, new york 11209 • p.718-630-1000 • f.718-630-1446**
- **stepping stones –the next step • 9321 ridge boulevard • brooklyn, new york 11209 • p.718-630-1001**

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ________________

City/Borough	State	Zip Code	School/Center/Camp Name	District Number ___ ___ / ___ ___ ___	Phone Numbers Home ________ Cell ________ Work ________

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ____________________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ____________________

☐ Foods *(list)* ____________________

☐ Other *(list)* ____________________

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability

Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ____________________
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

____

PHYSICAL EXAM Date of Exam: ___ /___ /___

Height	________ cm	(___ ___ %ile)
Weight	________ kg	(___ ___ %ile)
BMI	________ kg/m^2	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	________ cm	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	________ / ________	

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ________

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____/____/____ ____/____/____	________ µg/dL ________ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____/____/____	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	____/____/____	________ g/dL ________ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ____ /____ Left ____ /____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

												IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___		Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___		Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___		Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___		Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___		Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___		Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other ________	___/___/___	________	___/___/___		Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

____________________ ________

____________________ ________

____________________ ________

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ____________________

Follow-up Needed ☐ No ☐ Yes, for ____________________ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ____________________

Health Care Practitioner Signature		Date Form Completed _____ /_____ /_____
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	
Facility Name	National Provider Identifier (NPI)	
Address	City	State Zip
Telephone	Fax	Email

DOHMH ONLY — **PRACTITIONER I.D.** ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: _____ / _____ / _____ **I.D. NUMBER** ☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐

Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

***Instructions**: The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.*

I, _____, authorize this child care center to release my child,
(parent/ guardian name)

_____, to the individuals I have identified below.
(child name)

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Parent/ Guardian Signature: _____

Date: _____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

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CAMP PERMISSION FORMS

Child's Name _____

Social Media / Photo Release Form

I give Stepping Stones permission to take photographs of my child _____(name) throughout the summer in the activities they participate in. I give Stepping Stones permission to use these photographs of events, lessons, children at play, trips, etc. to be used on the school website, school social media accounts, etc.

Parent Signature _____ Date_____

Park and School Yard Permission

*The Toddler Group does not leave the building.

I give Stepping Stones permission to take my child _____(name) to the PS 185 school yard, the park on Colonial Road and 84th Street. I understand that if my child attends the Next Step location my child may attend the park on Shore Road and 95th Street. I give Stepping Stones permission to take my child on nature walks and periodic walking trips in the neighborhood. I understand that my child must wear a face covering when they are walking to the park/school yard/trip and when they cannot socially distance from others while there.

Parent Signature _____ Date_____

Insect and Bug Repellent Permission

I give Stepping Stones' personnel permission to apply _____(name of repellent) to my child _____ during the hours my child is in camp when deemed necessary. All insect repellents will be provided by the parent/guardian in the original container, with a valid expiration date, where applicable, labeled clearly with the child's name and give directly to the child's camp counselor. Insect repellent will be applied one time per day in the morning based on guideline from the American Academy of Pediatrics.

Parent Signature _____ Date_____

I agree to put sunblock on my child before they attend camp and I understand that Stepping Stones is not permitted to apply sunscreen. I understand that my child can apply the sun screen if he or she can.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /

Date of Birth: / / Current Weight: lbs.

Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e.***, ***air/skin contact/ingestion, etc.***):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:

☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:

☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

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

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

Asthma Action Plan

Medical Record #:	Updated On:

[To be completed by health care provider]

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

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

Asthma Triggers: ❑ Colds ❑ Exercise ❑ Animals ❑ Dust ❑ Smoke ❑ Food ❑ Weather ❑ Other

If Feeling Well (Green Zone)

Tale Every Day Long – Term Control Medicines

You have all of these:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone)

Take Every Day Medicines and Add these Quick-Relief Medicines

You have any of these:
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone)

Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature _____ Date _____

Patient/Guardian Signature [I have read and understood these instructions] _____ Date _____

NYC Health

Citywide Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 10/13

WHITE - PATIENT COPY
PINK - SCHOOL/DAY CARE COPY
YELLOW - PROVIDER COPY

COPY FOR PATIENT