U.S. House of Representatives
"A Capitol Experience" Summer Enrichment Program

REGISTRATION FORM

Please complete and return this form, accompanied by applicable fees (check or money order payable to U.S. Treasury) to: U.S. House of Representatives Child Care Center, Room 1100, O'Neill HOB, 200 St. SW, Washington, DC 20515.

All information is confidential.

Child's Information

Child's Name _____ Nickname _____ Sex: M ☐ F ☐

Age _____ Date of Birth _____ Entering Grade _____ in September 2023

Address _____ City _____ State _____ Zip _____

Child's City and State of Birth: _____ Child is a U.S. Citizen Y ☐ N ☐

Parent/Guardian Information

Parent/Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

Email _____

Place of Employment _____

Office Name _____

Parent/Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

Email _____

Place of Employment _____

Office Name _____

Emergency Contact Information

Name _____

Relationship to Child _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

Name _____

Relationship to Child _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

U.S. House of Representatives
"A Capitol Experience" Summer Enrichment Program

REGISTRATION FORM

Please register my child for the following session (held Monday through Friday 9am-4pm)

Session 1: ☐ July 7 to July 18

Session 2: ☐ July 21 to August 1

The cost of each two-week session is $825. Families registering multiple children will receive 15% off their total fee. **Payment in Full is required for enrollment and must accompany the completed Capitol Experience Summer Enrichment Enrollment Packet.**

Return, along with the applicable fees (check or money order payable to U.S. Treasury), to:
U.S. House of Representatives Child Care Center
Room 1100, O'Neill HOB
200 C St. SW
Washington, DC 20515

Upon acceptance of your application and payment, you will receive confirmation and additional program materials. Checks will not be deposited until there is confirmation of available space for Session(s) chosen.

- I understand my child will not be able to attend until a completed health certificate form is received by the Capitol Experience Summer Enrichment Program, documenting up to date immunizations and a physical exam within the last year.
- I understand that the Capitol Experience Summer Enrichment Program is an activity based program where participants may be away, at times, from the House campus, participating in activities at other facilities and utilizing various modes of transportation (primarily walking and metro).
- I certify that the above named child on this registration form is physically and mentally prepared to participate in all activities. I understand it is my responsibility to bring any needed accommodations, special conditions or concerns about my child to the program's attention.
- I understand that I will assume full responsibility for any accidents incurred, thereby releasing the U. S. House of Representatives, its staff and its Directors of all liability. I give my permission for my child to receive medical treatment in case of a medical emergency.
- I agree to instruct my child to observe the rules and regulations governing the activities of the Summer Enrichment Program.
- Unless written notification is submitted stating otherwise, I authorize the The Capitol Experience Summer Enrichment Program to take and use photographs, videos, and other presentations of my child and/or their work for purposes which include but are not limited to: projects & displays, parent communication, distribution to all participants (in print and/or electronically) for purposes that publicize, promote, or demonstrate the functions, daily activities, explorations, special events and field trips of the participants and its staff.
- I understand that the Director reserves the right to withdraw a participant when in his/her judgment the participant's and/or family's behavior or actions are deemed harmful, impact the smooth functioning of the group or activity, or who will not abide with the rules and policies of the summer enrichment program.

☐ _____ ☐ _____

Parent/Guardian Signature **Date**

☐ _____ ☐ _____

Parent/Guardian Signature **Date**

Child's Name _____

2025

A CAPITOL EXPERIENCE

SUMMER ENRICHMENT PROGRAM

U.S. House of Representatives Child Care Center

Use of Images Authorization

Child's Name _____

The Capitol Experience Summer Enrichment Program is designed to provide an enriching educational experience for all participants. Children will experience a wide variety of quality educational, motivational, and recreational activities in a safe, healthy, and fun atmosphere.

Photographs, videos, activities, and other presentations of participants individually and in groups may be used in a variety of ways which include but are not limited to: projects & displays, parent communication, and for distribution to all participants (in print and/or electronically). These items may include the children's names and/or ages, and may be visible to others not enrolled in the program. Children's last names will not be used for purposes outside of the Capitol Experience Summer Enrichment Program.

The Capitol Experience Summer Enrichment Program may also use these images for purposes that publicize, promote, or demonstrate the functions, daily activities, explorations, special events and field trips of the participants and its staff.

☐ I give permission for the Capitol Experience Summer Enrichment Program to take and use photographs, videos, and other presentations of my child and/or their work for the purposes named above.

☐ **I do not** give permission for The Capitol Experience Summer Enrichment Program to take and use photographs, videos, and other presentations of my child and/or their work for the purposes named above.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Child's Name: _____

2025

A CAPITOL EXPERIENCE

SUMMER ENRICHMENT PROGRAM

U.S. House of Representatives Child Care Center

Authorized Child Pickup Form

It is strongly recommended that you have an alternative for pickup if circumstances prevent you from picking up your child.

I authorize the following person(s) to pick up my child in the event I am unable:

Child's Name_____

1. Name _____ Relationship to child: _____

Address 1_____ Phone: _____

2. Name _____ Relationship to child: _____

Address 2 _____ Phone: _____

3. Name _____ Relationship to child: _____

Address 3 _____ Phone: _____

If someone on this list will be picking up your child, please call or write a note for the Summer Enrichment Program staff. They will be asked to show a photo ID at the time of pickup.

Parent/Guardian Signature: _____Date: _____

Child's Name: _____

PARENT/GUARDIAN CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT
(To be completed for each Summer Enrichment attendee)

U.S. HOUSE OF REPRESENTATIVES CHILD CARE CENTER
SUMMER ENRICHMENT PROGRAM
Room 1100, O'Neill House Office Building
Washington, DC 20515
(202) 225-6100

CHILD'S NAME (First, Middle & Last) _____

HOME ADDRESS _____

DATE OF BIRTH _____

PARENT/GUARDIAN NAME _____
RELATIONSHIP TO CHILD _____
PHONE (WORK) _____
(HOME) _____
(CELL)_____
EMAIL _____

PARENT/GUARDIAN NAME _____
RELATIONSHIP TO CHILD _____
PHONE (WORK) _____
(HOME) _____
(CELL)_____
EMAIL _____

PEDIATRICIAN _____
PHONE _____
ADDRESS _____

DENTIST (family or child) _____
PHONE _____

FRIEND/NEIGHBOR _____
PHONE _____

OTHER _____
PHONE _____

ALLERGIES (food, medications, insect bites, skin irritants, etc.) _____
_____

ONGOING MEDICATIONS _____
_____

ANY NOTABLE CONDITIONS _____
_____

PARENT/GUARDIAN CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT
(To be completed for each Summer Enrichment attendee)

In the event I cannot be reached, I hereby authorize the U.S. House of Representatives Child Care Center Summer Enrichment Program to transport or arrange transportation for my child to the emergency room at Children's Hospital, or the nearest hospital. I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). I agree to accept financial responsibility for all medical expenses incurred.

ANESTHESIA, SEDATION AND ANALGESIA: I consent to the administration of anesthesia or sedation, if applicable. I understand that complications of anesthesia or deep sedation are rare, but may include cardiac arrest (heart stoppage), brain damage, or death. Complications of moderate sedation include nausea, agitation, and allergic reactions to the medicine. Also, if the child becomes deeply sedated, there can be difficulty breathing and loss of oxygen to the brain. If you have any questions concerning the administration of anesthesia, sedation and analgesia please contact your family doctor.

BLOOD AND BLOOD PRODUCTS: I understand that blood or blood products will be given if needed. I understand that the risks are rare but include fever, chills, rash, itching, back pain, kidney problems, shortness of breath and hepatitis. The risk of other diseases such as HIV/AIDS and death is very low.

CONSENT: I have read, been informed, and understand the above and any attached information. I consent to any procedures or treatments that may be required in an emergency situation and to the use of anesthesia/sedation or blood/blood products if required. This consent lasts for the duration of the continuous course of treatment, with the exception of surgical informed consent.

If you have any questions, please contact the Office of the Attending Physician at 225-5421.

HEALTH INSURANCE PROVIDER _____

INSURANCE I.D. NUMBER _____

PARENT/GUARDIAN CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT
(To be completed for each Summer Enrichment attendee)

_____ _____
PARENT/GUARDIAN DATE PARENT/GUARDIAN DATE

STATE OF _____)
) ss
COUNTY OF _____)

The foregoing Consent was acknowledged before me this _____ day
of _____, 20__, by _____
and _____.

_____
Notary Public

My commission expires _____

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ☐ Male ☐ Female ☐ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other ☐ Prefer not to answer	
Race: *(check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ☐ Medicaid ☐ Private ☐ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ☐ Yes ☐ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____ /_____ ☐ NML ☐ ABNL	**Weight:** ☐ LB ☐ KG	**Height:** ☐ IN ☐ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ☐ Corrected ☐ Uncorrected ☐ Wears glasses ☐ Referred ☐ Not tested

Hearing Screening: *(check all that apply)* ☐ Pass ☐ Fail ☐ Not tested ☐ Uses Device ☐ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ☐ Asthma
- ☐ Autism
- ☐ Behavioral
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Developmental
- ☐ Diabetes
- ☐ Failure to thrive
- ☐ Heart failure
- ☐ Kidney failure
- ☐ Language/Speech
- ☐ Obesity
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle cell
- ☐ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ☐ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ☐ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ☐ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB? ☐ High → *complete skin test and/or Quantiferon test* ☐ Low	**Skin Test Date:**	**Quantiferon Test Date:**
	Skin Test Results: ☐ Negative ☐ Positive, CXR Negative ☐ Positive, CXR Positive ☐ Positive, Treated	
	Quantiferon Results: ☐ Negative ☐ Positive ☐ Positive, Treated	
Additional notes on TB test:		

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ☐ Normal ☐ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**
HGB/HCT Test Date:		**HGB/HCT Result:**	

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

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**

PLACE PICTURE HERE

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

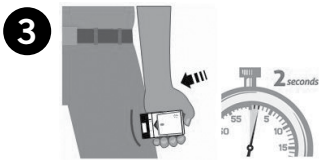
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

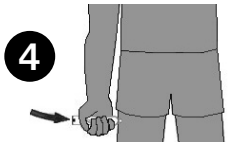
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



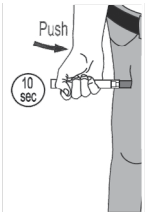
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

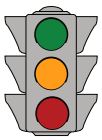
NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

ASTHMA ACTION PLAN

This form expires 1 year after submission

Last, First, Name	Date of Birth	Date
Health Care Provider	Provider's Phone	
Emergency Contact	Parent's Phone	School
Additional Emergency Contact	Contact Phone	Last Four Digits of SSN



GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add RESCUE medicine

RED means EMERGENCY!

Inhalers work better with spacers.
Always use with a mask when prescribed.

Asthma Triggers Identified (Things that make your asthma worse):
Circle what applies

Colds	Smoke (tobacco, incense)	Pollen
Animals	Strong odors	Mold/moisture
Dust	Pests (rodents, cockroaches)	Stress/emotions
Gastroesophageal reflux	Exercise	Seasons: Fall, Winter, Spring, Summer

Other: _____

Date of last medical appointment:

Green Zone: Doing well-continue control medicines DAILY

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area: _____to_____
(More than 80% of Personal Best)

Personal best peak flow:_____

Always rinse mouth after using your daily inhaled medicine. **Inhalers work better with spacers**

- ■ No control medicines required.
- ■ _____,_____ puff(s) (MDI) _____times a day
  Inhaled corticosteroid or inhaled corticosteroid/long-acting β−agonist
- ■ _____,_____ nebulizer treatment(s)_____ times a day
  Inhaled corticosteroid
- ■ _____ , take_____ by mouth once daily at bedtime
  Leukotriene antagonist
- ■ For asthma with exercise, ADD:
  _____ puff(s) (MDI) 15 minutes before exercise
  Fast-acting inhaled β−agonist
- ■ For nasal/environmental allergy, ADD:
  _____

Yellow Zone: Caution! –Continue CONTROL Medicines and ADD RESCUE Medicines

When you have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing
- Exposure to known trigger.

Peak flow in this area: _____to_____
(50%- 80% of Personal Best)

- ■_____ , _____ puff(s) MDI with spacer every _____ hours as needed
  Fast-acting inhaled β−agonist

OR

- ■ _____ , _____ nebulizer treatment(s) every _____ hours as needed
  Fast-acting inhaled β−agonist
- ■ Other_____

Do not leave child alone, and if the child should feel better within 20-60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the health care provider right away*
OR if you do feel better continue treatments every 4-6 hours as needed for 1-2 days.

Red Zone: EMERGENCY! – Continue CONTROL & RESCUE Medicines and GET HELP!

When you have **ANY** of these :

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area: _____to_____
(Less than 50% of Personal Best)

- ■_____ , _____ puff(s) MDI with spacer every **15 minutes**, for **THREE** treatments
  Fast-acting inhaled β−agonist

OR

- ■ _____ , _____ nebulizer treatment every **15 minutes**, for THREE treatments
  Fast-acting inhaled β−agonist

Call your Healthcare Provider while giving the treatments.

- ■ Other_____

IF YOU CANNOT CONTACT YOUR HEALTHCARE PROVIDER:
Call 911 for an ambulance or go directly to the Emergency Department!

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

ASTHMA ACTION PLAN

This form expires after 1 year

REQUIRED Healthcare Provider Signature:

_____ Date: _____

REQUIRED Parent/Guardian Signature:

_____ Date: _____

Follow up with primary care provider in 1 week or:

_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.

Healthcare Provider Initials:

- _____ This student is not approved to self-medicate.
- _____ This student is capable and approved to self-administer the medicine(s) named above.

As the PARENT/GUARDIAN:

- _____ I hereby authorize a trained school employee, if available, to administer medication to the student.
- _____ I hereby authorize the student to possess and self-administer medication.
- _____ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Health Care Provider Stamp below:

Stepwise Approach for Managing Asthma in Children and Adults (from 2007 NAEPP Guidelines)

Criteria apply to all ages unless otherwise indicated	IMPAIRMENT					RISK	
	Daytime Symptoms	**Nighttime Awakenings** <5 Years / ≥5 years	**Interference with normal activity**	**Short-acting beta-agonist use**	**FEV1 % predicted (n/a in age <5)**	**Exacerbations requiring oral systemic corticosteroids**	
Classification of Asthma SEVERITY: TO DETERMINE *INITIATION* OF LONG-TERM CONTROL THERAPY Consider severity and interval since last exacerbation when assessing risk.							**Step**
Severe Persistent	Throughout the day	>1x/week	Often 7x/week	Extremely limited	Several x/ day	<60%	**<5:** ≥2 in 6 months OR ≥4 wheezing episodes in 1 year lasting >1 day AND risk factors for persistent asthma	<5: **Step 3** 5-11: **Step 3 Medium-dose ICS option *or* Step 4** 12-adult: **Step 4 *or* 5** All ages: *Consider short course OCS*
Moderate Persistent	Daily	3-4x/ month	>1x/week but not nightly	Some	Daily	60-80%		<5: **Step 3** 5-11: **Step 3 Medium-dose ICS option *or* Step 4** 12-adult: **Step 4 *or* 5** All ages: *Consider short course OCS*
Mild Persistent	>2 days/week but not daily	1-2x/ month	3-4x/month	Minor	>2 days/ week but not daily	>80%	**5-adult:** ≥2/year	**Step 2**
Intermittent	≤2 days/week	0	≤2x/month	None	≤2 days/week	>80%	0-1/year	**Step 1**

Classification of Asthma CONTROL: TO DETERMINE ADJUSTMENTS TO CURRENT CONTROL MEDICATIONS Consider severity and interval since last exacerbation and possible medication side effects when assessing risk. **<12 years** **12-adult**								**Action:** In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.
Very Poorly Controlled	Throughout the day	≥2x/week	≥4x/week	Extremely limited	Several times/day	<60%	**<5:** >3/year **5-adult**: ≥2/year	**Step up 1-2 steps.** Consider short course OCS. Reevaluate in 2 weeks. For side effects, consider alternate treatment.
Not Well Controlled	>2 days/week	≥2x/ month	1-3x/week	Some	>2 days/week	60-80%	**<5:** 2-3/year **5-adult:** ≥2/year	**Step up at least 1 step.** Reevaluate in 2-6 weeks. For side effects, consider alternate treatment.
Well Controlled	≤2 days/week	≤1x/month	≤2x/month	None	≤2 days/week	>80%	0-1/year	**Maintain current treatment.** Follow-up every 1-6 months. Consider step down if well controlled for at least 3 months.

Daily Doses of common inhaled corticosteroids	**Fluticasone** MDI (mcg)			**Budesonide** Respules (mcg)			**Beclomethasone** MDI (mcg)			**Fluticasone/ Salmeterol** DPI	**Budesonide/ Formoterol** MDI
	Low	Medium	High	Low	Medium	High	Low	Medium	High		
<5 years	176	>176-352	>352	0.25-0.5	>0.5-1	>1	n/a	n/a	n/a	n/a	n/a
5-11 years	88-176	>176-352	>352	.5	1	2	80-160	>160-320	>320	100/50 mcg 1 inhalation BID	80 mcg/4.5 mcg 2 puffs BID
12 years-adult	88-264	>264-440	>440	n/a	n/a	n/a	80-240	>240-480	>480	Dose depends on patient	Dose depends on patient

Abbreviations:
SABA: Short-acting beta-agonist
LABA: Long-acting beta-agonist
LTRA: Leukotriene-receptor antagonist
ICS: Inhaled corticosteroids
LD-ICS: Low-dose ICS
MD-ICS: Medium-dose ICS
HD-ICS: High-dose ICS
OCS: Oral corticosteroids
CRM: Cromolyn
NCM: Nedocromil
THE: Theophylline
MLK: Montelukast
ALT: Alternative

Step 1

Preferred
SABA prn

Step 2

Preferred
LD-ICS

Alternative
<5: CRM or MLK

5-adult: CRM, LTRA, NCM, or THE

Step 3

Preferred
<5: MD-ICS

5-11: *EITHER* LD-ICS plus LABA, LTRA or THE ***OR*** MD-ICS

12-adult: LD-ICS plus LABA ***OR*** MD-ICS

Alternative
12-adult: LD-ICS plus either LTRA, THE or Zileuton

Step 4

Preferred
<5: Medium-dose ICS plus either LABA or MLK

5-adult: MD-ICS plus LABA

Alternative
5-11: MD-ICS plus either LTRA or THE

12-adult: MD-ICS plus either LTRA, THE or Zileuton

Step 5

Preferred
<5: HD-ICS *plus either* LABA or MLK

5-11: HD-ICS *plus* LABA

12-adult: High-dose ICS *plus* LABA ***AND*** consider Omalizumab for patients who have allergies

Alternative
5-11: HD-ICS *plus either* LTRA or THE

Step 6

Preferred
<5: HD-ICS *plus either* LABA or MLK plus OCS

5-11: HD-ICS *plus* LABA *plus* OCS

12-adult: HD-ICS plus LABA *plus* OCS ***AND*** consider Omalizumab for patients who have allergies

Alternative
5-11: HD-ICS *plus either* LTRA or THE *plus* OCS

← Step down if possible (asthma well-controlled at least 3 months)/Step up if needed (check adherence, technique, environment, co-morbidities) →

Adapted from NAEPP. Please refer to individual drug prescribing information as needed

Authorization to Administer Medication

Child's Name _____ DOB: _____

The staff of the Summer Enrichment Program will administer over the counter (OTC) medication ONLY if it is in the original container and labeled with the child's first and last name; and will administer prescribed medication ONLY if it is in the original container with proper pharmacy labeling.

This form must be completed and signed by both the prescriber and parent/guardian before any medication can be given. Use a separate form for each medication. This form must be updated annually or as needed for medication or dose changes.

Because of possible adverse reactions, the first dose of any medication must be given by the parent/guardian.

Directions to staff of the Summer Enrichment Program for medication administration:

To be filled out by Prescriber	
Medication Name: **(required)**	
Dose: **(required)**	
Time/Frequency to give medication: **(required)**	
Route: **(required)**	
Reason medication is needed at HRCCC: **(required)**	
Date to start medication: **(required)** / /	Stop date: / /
Child allergies: **(required)**	
Current child weight: **(required)**	
Known side effects of medication:	
Plan of management of side effects:	
Precautions or restrictions:	
Additional instructions:	

_____ _____

Physician/Prescriber Signature Date Phone number

To be filled out by Parent/Guardian

By Signing Below, I give authorization to staff of the Summer Enrichment Program to administer the medication as directed above. I also give permission for the nurse or staff member to contact the prescribing health professional above about the administration of this medication. I also affirm that I have administered the first dose to my child and have not observed any adverse effects.

_____ _____

Name of Parent/Guardian Signature of Parent/Guardian Date

EMERGENCY CONTACT INFORMATION
SUMMER ENRICHMENT EMERGENCY EVENTS

Family ID #

_____

FOR OFFICE USE ONLY

Child's/Children's Name(s) _____

Parent/Guardian 1

Last Name_____

First name_____

Employer _____

Parent/Guardian 2

Last Name_____

First name _____

Employer _____

The HRCCC/SE Program uses the **House Alert** messaging system to notify families of Center emergency response actions (drill or actual). Employees of the House of Representatives, Senate, Architect of the Congress, and U.S. Capitol Police have access to the emergency notification system through their employer and should update their contact information through their employer's alert system. For House employees, this can be done at https://alert.house.gov/.

House Alert system notifications are sent in a "blast" configuration, meaning notifications to all devices are sent at the same time. **Please only include devices on which you wish to receive notifications.**

During a scheduled drill, the House Alert system will send notifications to electronic devices including computers connected to the House network*, mobile devices (via text message and/or a downloadable application*), and email.

During an emergency event, the House Alert system will send emergency notifications to electronic devices including computers connected to the House network*, mobile devices (via voice, text message and/or a downloadable application*), email, and landline phones.

**Capitol Hill employees only (House, Senate, AOC, LOC, USCP)*

House Alert text messages will be sent from 28462 and 24639. If you receive voice calls, the system will contact you from 855-284-6248. Please store these numbers in your mobile phone as "Capitol Hill Alerts" for easy identification.

As a reminder, our ability to contact you is based upon your supplying current contact information. **If at any time you move, change offices, or get a new phone number, it is your responsibility to notify summerenrichment@mail.house.gov by e-mail and complete an updated copy of this form.**

EMERGENCY CONTACT INFORMATION
SUMMER ENRICHMENT EMERGENCY EVENTS

Child's/Children's Name(s) _____

To prevent duplicate notifications, **the contact information below should include only that of individuals who are not employees of the of the House of Representatives, Senate, Architect of the Capitol, Library of Congress, and U.S. Capitol Police.**

Email notifications will be sent during scheduled drills and emergency events. Please list up to 3 email addresses to which you wish to receive notifications:

1. _____
2. _____
3. _____

SMS Text notifications will be sent during scheduled drills and emergency events. Please list up to 3 cellular devices to which you wish to receive text notifications:

1. _____
2. _____
3. _____

Voice notifications will be sent during emergency events only. Please list up to 4 phone numbers (specify device type work, cell, or home) to which you wish to receive voice notifications. Please note that there is a maximum of 3 numbers for each device type.

1. _____ Device Type _____
2. _____ Device Type _____
3. _____ Device Type _____
4. _____ Device Type _____