



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 2026

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 _____

Parent/Guardian Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Home Phone _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

Daytime Phone _____ Cell Phone _____

Email _____

Email _____

Place of Employment _____

Place of Employment _____

Office Name _____

Office Name _____

Emergency Contact Information

Name _____

Name _____

Relationship to Child _____

Relationship to Child _____

Home Phone _____

Home Phone _____

Daytime Phone _____ Cell Phone _____

Daytime Phone _____ Cell Phone _____

Child's Name _____

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 9 a.m. - 4 p.m.)

Session 1: _____ July 13 to July 24

Session 2: _____ July 27 to August 7

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 _____



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: _____



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 _____)
)
COUNTY OF _____) ss

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

Notary Public

My commission expires _____

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Home Address:		Apt:	City:	State: ZIP:	
Ethnicity: (check all that apply) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer					
Race: (check all that apply) <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer					
Parent/Guardian Name:			Parent/Guardian Phone:		
Emergency Contact Name:			Emergency Contact Phone:		
Insurance Type: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None		Insurance Name/ID #:			
Has the child seen a dentist/dental provider within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <u> / </u>	<input type="checkbox"/> NML <input type="checkbox"/> ABNL	Weight: <input type="checkbox"/> LB <input type="checkbox"/> KG	Height: <input type="checkbox"/> IN <input type="checkbox"/> CM	BMI:	BMI Percentile:
Vision Screening:	Left eye: 20/ <u> </u> Right eye: 20/ <u> </u>	<input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected	<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Referred	<input type="checkbox"/> Not tested	
Hearing Screening: (check all that apply)		<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	<input type="checkbox"/> Uses Device	<input type="checkbox"/> Referred

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

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

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?	Skin Test Date:		Quantiferon Test Date:	
	Skin Test Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive, CXR Negative <input type="checkbox"/> Positive, CXR Positive <input type="checkbox"/> Positive, Treated			
High → complete skin test and/or Quantiferon test	Quantiferon Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive		<input type="checkbox"/> Positive, Treated	
Low				

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	1 st Test Date:	1 st Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	1 st Serum/Finger Stick Lead Level:
	2 nd Test Date:	2 nd Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, Developmental Screening Date:	2 nd 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
Rotavirus (Recommended)		1	2	3			
Other		1	2	3	4	5	6
<input type="checkbox"/> 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:

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Hib	<input type="checkbox"/> HepB	<input type="checkbox"/> Polio	<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Varicella	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> HepA	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> 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.

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Hib	<input type="checkbox"/> HepB	<input type="checkbox"/> Polio	<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Varicella	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> HepA	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> 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.

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:

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


1. INJECT EPINEPHRINE IMMEDIATELY.

- 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:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- 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: _____

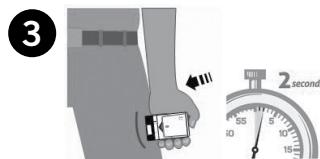
Antihistamine Dose: _____

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



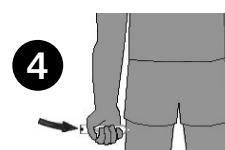
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



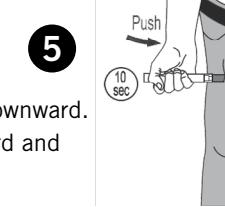
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

ASTHMA ACTION PLAN

This form expires 1 year after submission

Last, First, Name	Date of Birth	Date	 <p>GREEN means Go! Use CONTROL medicine daily</p> <p>YELLOW means Caution! Add RESCUE medicine</p> <p>RED means EMERGENCY!</p> <p>Inhalers work better with spacers. Always use with a mask when prescribed.</p>
Health Care Provider	Provider's Phone		
Emergency Contact	Parent's Phone	School	
Additional Emergency Contact	Contact Phone	Last Four Digits of SSN	
Asthma Triggers Identified (Things that make your asthma worse): Circle what applies			Date of last medical appointment:
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: _____			

Green Zone: Doing well-continue control medicines DAILY

You have <u>ALL</u> of these:	<p>Always rinse mouth after using your daily inhaled medicine. Inhalers work better with spacers</p> <ul style="list-style-type: none"> ■ 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 ■ _____ Leukotriene antagonist, take _____ by mouth once daily at bedtime ■ For asthma with exercise, ADD: Fast-acting inhaled β-agonist _____ puff(s) (MDI) 15 minutes before exercise ■ For nasal/environmental allergy, ADD: _____
Peak flow in this area: _____ to _____ (More than 80% of Personal Best)	
Personal best peak flow: _____	

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

When you have <u>ANY</u> of these:	<ul style="list-style-type: none"> ■ _____ puff(s) MDI with spacer every _____ hours as needed Fast-acting inhaled β-agonist ■ _____ nebulizer treatment(s) every _____ hours as needed Fast-acting inhaled β-agonist ■ Other _____ <p>***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****</p> <p>OR if you do feel better continue treatments every 4-6 hours as needed for 1-2 days.</p>
Peak flow in this area: _____ to _____ (50%– 80% of Personal Best)	

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

When you have <u>ANY</u> of these :	<ul style="list-style-type: none"> ■ _____ puff(s) MDI with spacer every <u>15 minutes</u>, for <u>THREE</u> treatments Fast-acting inhaled β-agonist ■ _____ nebulizer treatment every <u>15 minutes</u>, for <u>THREE</u> treatments Fast-acting inhaled β-agonist ■ Other _____ <p>Call your Healthcare Provider while giving the treatments.</p> <p>IF YOU CANNOT CONTACT YOUR HEALTHCARE PROVIDER: Call 911 for an ambulance or go directly to the Emergency Department!</p>
Peak flow in this area: _____ to _____ (Less than 50% of Personal Best)	

ASTHMA ACTION PLAN

This form expires after 1 year

REQUIRED Healthcare Provider Signature: <hr/> REQUIRED Parent/Guardian Signature: <hr/> Follow up with primary care provider in 1 week or: <hr/>	<p>SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH: <i>Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.</i></p> <p>Healthcare Provider Initials:</p> <p><input type="checkbox"/> _____ This student is not approved to self-medicate.</p> <p><input type="checkbox"/> _____ This student is capable and approved to self-administer the medicine(s) named above.</p> <p>As the PARENT/GUARDIAN:</p> <p><input type="checkbox"/> _____ I hereby authorize a trained school employee, if available, to administer medication to the student.</p> <p><input type="checkbox"/> _____ I hereby authorize the student to possess and self-administer medication.</p> <p><input type="checkbox"/> _____ 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.</p>
Health Care Provider Stamp below: <hr/>	

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)		
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	<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								Action: In children <5, consider alternate diagnosis or adjusting therapy if no benefit seen in 4-6 weeks.
Consider severity and interval since last exacerbation and possible medication side effects when assessing risk.								
<12 years				12-adult				
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			Budesonide			Bclometasone			Fluticasone/ Salmeterol		Budesonide/ Formoterol	
	MDI (mcg)	Low	Medium	High	Respules (mcg)	Low	Medium	High	MDI (mcg)	DPI	MDI		
<5 years	176	>176-352	>352		0.25-0.5	>0.5-1	>1		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		Step 3		Step 4		Step 5		Step 6	
		Preferred LD-ICS	Alternative <5: CRM or MLK	Preferred <5: MD-ICS	5-11: EITHER LD-ICS plus LABA, LTRA or THE OR MD-ICS	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: High-dose ICS plus LABA AND consider Omalizumab for patients who have allergies	Preferred <5: HD-ICS plus either LABA or MLK plus OCS	5-11: HD-ICS plus LABA 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

Child's/Children's Name(s) _____	Parent/Guardian 1	Parent/Guardian 2	Family ID # _____
Last Name _____	First name _____	Last Name _____	FOR OFFICE USE ONLY
Employer _____	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 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 _____