DUE WEST UMC PRESCHOOL MINISTRY
STUDENT AND FAMILY INFORMATION 2020-2021

You can help us plan for your child's needs, understand concerns and responses, and support and encourage your child if you provide the following information. The information will remain confidential, and we hope you will update it when needed.

Child's Name________________________________ Name used___________________________

Address____

City_________________________ Zip Code_____________ Subdivision____________________

Date of Birth _________________ Age on 9/1/20____________ Sex: M________ F________

Parent/Guardian #1's Name____
Occupation____

Employer______________________________________Position____________________________

Cell Phone ________________ Home Phone________________ Business Phone______________
Please mark the best number for us to call.
Email addresses: Parent 1 __________________________ Parent 2__________________________

Parent/Guardian #2's Name____
Occupation____

Employer______________________________________Position____________________________

Cell Phone__________________ Home Phone__________________ Business Phone____________
Please mark the best number for us to call.

Church attended____

Parents are: _____Married _____ Separated _____ Divorced _____ Widowed ______Single
If divorced or separated, please describe custody and/or visitation agreement concerning your child:____
____

Allergies. What is your child's nonfood allergy and how does it affect him/her? ________________
____ **If an inhaler is necessary, a permission form must be filled out and the inhaler left at school in the class backpack**
Food allergy:____
__minor allergy __serious allergy __parent preference __religious reasons __other
Describe your child's typical reaction to this food_______________________________________
Must this food be avoided in all forms and even in small amounts? ___________________________
Does your child require the use of an EpiPen in the event of a severe allergic reaction? ___________
If so, we must have two Epi Pens at the school at all times and a completed allergy form.
What actions would you like us to take if we observe what appears to be an allergic reaction?
____
____
****Please discuss this with your child's teacher as well as writing this information here.***

STUDENT AND FAMILY INFORMATION 2020-2021

Does either parent's work require them to be out of town frequently? No ______
Yes (please explain) ____

Please list other people (besides child & child's parents) in your household:

Name Age Relationship

____
____
____
____

Have there been births, deaths, adoption or other changes in the family structure that affected your child? If so, please explain and describe the effect on your child.

____
____

What opportunities does your child currently have to play with other children?
_____Sunday school/church ___siblings, cousins or other family ___ neighborhood
_____preschool or MMO name (if not Due West) ______________________
When does your child attend other programs?

____

Has your child attended school previously? Yes______ No ________
Where did they attend? ______________________ When did they attend?______________

Does your child have a diagnosis or educational label? ______________________

Does your child have a medical condition that would be helpful for the teachers to know about?

____

Has your child attended physical, occupational, speech, play or vision therapy? Yes______No______
How can we help support their success at school? ______________________

Is your child on any medication? If so, what medication, in what dose, for what condition, and how does it affect him/her? We do not administer medication at school (except inhalers and Epi pens.)

____

Has your child had a serious illness, surgery, or hospital stay? If so, describe it and your child's reaction. ____

How do you discipline your child? ______________________________
____

Does your child have any particular fears? ______________________________

Is there anything else about your child we should know?______________________
____
____

What do you expect from your child's preschool experience? ______________________
____
____

DUE WEST UMC PRESCHOOL MINISTRY

EMERGENCY INFORMATION AND RELEASE FORMS **2020-2021**

****

I give my consent for any staff member of Due West UMC Preschool Ministry or Church or any qualified medical personnel to act on my behalf in securing and administering necessary emergency medical care and treatment for my child while on church property or attending a preschool field trip.

____

Parent's Signature   Date

****

Child's Name____

Date of Birth ______________________ Social Security Number___________________________

Parents' Names______________________________________ Home Phone___________________

Dad's Cell Phone________________________ Mom's Cell Phone___________________________

Dad's Work Phone_________________________ Mom's Work Phone_______________________

Please mark the best number for us to call in an emergency.

In case of an emergency and I cannot be reached, these people have my permission to pick up my child:

****This list is NOT for regular afternoon pick-up changes.** Those changes require a note or phone call.

Name   Phone number   Relationship to child

____

____

____

___

____

_

Allergies (include reactions to the allergen)

____

____

____

_

Name of Insurance Company____

Name of Primary Insurance Holder____

Contract or Group Number____

Mailing Address ____

____

Doctor's Name & Phone____

Dentist's Name & Phone____

Due West UMC Preschool Ministry Admission Policies 2020-2021
Please initial that you've read the following policies

Admission Policies
_____DWUMC Preschool accepts students without regard to race, creed, sex, religion or national origin
Financial Policies
_____DWUMC Preschool's tuition is based on a child's commitment to one full year. As a courtesy, tuition payments are divided into 10 equal installments, payable monthly, one month in advance.
_____The registration fee is due at the time of enrollment in order to complete the registration process and is **Non-refundable.** Students will be placed on a class list only if tuition payments for the current school year are up to date
_____ August tuition is due July 1st and is **Non-refundable.** If August tuition is not submitted by July 10th, 2020, your child is subject to forfeiting their place in the program.
_____Activity fees are due August 15th and are **Non-refundable**
_____My child's participation in the Preschool program is subject to the timely payment of tuition and fees due
_____Tuition is due one month in advance and a late fee will be charged for tuition received after the 5th of the month. There will be a $15 late fee charged to your child's account if your tuition is received after the 5th of the month. Tuition received after the 10th will be charged a $20 late fee. Late fees will continue to accrue until payments are received and the account is made current.
_____I am to give one month's notice in case there is a need to withdraw my child from the Preschool. If I fail to do so I am responsible for paying that month's tuition. All tuition payments are non-refundable and non-transferable.
_____There will be no financial credits due to illness, inclement weather, travel or any other reason. If my child will be absent for an extended period of time, I am responsible for paying all monies due in order to retain placement in the program. Failure to do so will result in forfeiture of my child's enrollment in the program.
Health and Wellness Policies
_____ A certificate of Immunization (form 3231) & Physician Statement are due on or before the first day of school. My child will not be allowed to attend without meeting this requirement. Immunization forms may expire during the school year, therefore must be renewed within 30 days of expiration.
_____ All children attending 3-year old classes and above must be potty-trained and able to independently use the restroom when school begins. Each child should be wearing underwear, not Pull-ups or diapers, at school.
Other Policies
______DWUMC Preschool has an exemption from the State of Georgia not to be licensed because the children are not in our facility for more than 4 hours per day. Our preschool is a program of excellence in the North Georgia United Methodist Conference.
______Teachers cannot be guaranteed due to class size, boy/girl ratios and balancing birthdays.
Media Release
______During the school year, photos/images are taken of children and classes at DWUMC Preschool, for the school and church use only. By initialing, you are giving your consent which will enable the school/church to use a photo/image of your child for school/church purposes only.
______I give DWUMC Preschool permission to print my child's name and family's name in a class directory, with the understanding that it is for school use only and not for commercial purposes or solicitations.
Consent for Medical Treatment
To whom it may concern:
It is mutually understood that in an event of an accident or illness regarding my child while in the care of DWUMC Preschool, the staff shall use their best efforts to contact me. In the event that I am not immediately available, the staff is authorized to secure such medical care as the situation may reasonably warrant.
I, ________________________, hereby authorize Due West UMC Preschool Ministry to sign on my behalf any and all forms required in order to obtain emergency medical or hospital care for my child,
________________________, and specifically authorize and request that necessary treatment be provided to my child. A photocopy of this authorization and consent for medical treatment shall have the same force and effect as the original.
It is agreed that where the school has acted in good faith to secure appropriate treatment following an accident or an illness involving my child, any and all liability as might exist is expressly waived by me, the parent or guardian.
I have read and understand the above DWUMC Preschool policies.
________________________________Parent signature ______________date

Authorization for Administration of Inhaled Asthma Medication

Student's Name: ____
Sex: _____ Female _____Male Birthdate: ____/_____/_____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's name ____
Phone number ____________________ Fax Number____________________
Emergency Contact Number ________________________________
Diagnosis: ____
Name of Medicine: ____
Form: _______________________ Dose: ______________________

Medicine is administered daily and time: ___________ ___Yes ___No
Medicine is administered when needed. ___Yes ___ No
Indications:____
____
If needed, how soon can administration of medicine be repeated?__________
____
The medication cannot be repeated more than ____________________
Side effects: ____
____
Comments: ____
____
Physician Signature _______________________________________
Date ____

FOR COMPLETION BY PARENT:

Mother's Name _________________________ Cell phone # ______________
Father's Name _________________________ Cell phone # ______________
Home phone # _________________________ Emergency # ______________

As the parent of the above named student, I ask that assistance be provided to my child in taking the medicine(s) listed above at school by authorized staff. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent Signature and Date ____

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: ____________

GO

Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER

Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow: reading below ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

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

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: __________

Allergic to: ______________________

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

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

Extremely reactive to the following allergens: ______________________

THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

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

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

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

OR A COMBINATION of symptoms from different body areas.

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

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

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: __________

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

Antihistamine Brand or Generic: __________

Antihistamine Dose: __________

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

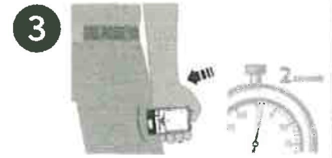
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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

FARE
Food Allergy Research & Education

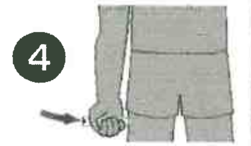
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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



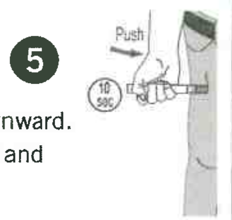
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

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



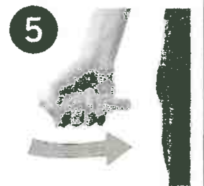
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle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

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



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

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



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

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

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

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

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

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

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

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: ____________

PARENT/GUARDIAN: ____________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

DUE WEST UMC PRESCHOOL MINISTRY

HEALTH FORM 2020-2021

THIS FORM IS TO BE COMPLETED AND SIGNED BY A DOCTOR.

Child's Name____

Physician's Name & Phone ____

Any allergies? ____
____

Any infectious diseases?
____
____

Any special medical needs? ____
____

Any medical history of which the school should be aware? ______________________________
____ _______________
____

____
Physician's Signature Date

At the beginning of the year this form must be in the preschool office by the first day of school along with a current GEORGIA IMMUNIZATION CERTIFICATE #3231 with the date of the next immunization due.
Children who register after the school year has begun must have this form in the preschool office within 30 days of the child's first day in school along with a current GEORGIA IMMUNIZATION CERTIFICATE #3231 with the date of the next immunization due.