THOMAS MACLAREN SCHOOL

HEALTH CARE PLAN
LETTER OF EXPLANATION

Dear Parents and Guardians:

Welcome to the 2022-2023 school year at Thomas MacLaren School! Every year it is helpful for us to have an update to our records if your child/ren have asthma, allergies, celiac disease, diabetes, migraines, seizures or any other health care issue. This allows us to better care for your child/ren throughout the school year and helps decrease the number of interruptions to their learning due to illness or complications from their health concerns.

All of the forms included in these health care plans (HCPs) must be filled out completely by either you or a health care provider with prescriptive authority. Please note that both the parent/guardian and the health care provider need to sign the documents.

If your child/ren will need to carry a rescue inhaler, Epi-Pen®, or diabetes supplies with them this year, then please fill out the *Contract to Carry* form and return to the front desk prior to sending your child/ren to school with their medication. Unfortunately, we are no longer able to administer your child/ren's emergency medication without a signed HCP and a completed *Authorization for the Administration of Medication by School Personnel.*

For your reference, all of the links for these forms and packets can be found on the school website: www.maclarenschool.org under the **Parent** tab in the **Health Information** section.

Thank you for letting us partner with you to make sure that your child/ren have a healthy and safe school year. If you have any questions or concerns, please don't hesitate to contact me.

Kind Regards,

Terra Fisk, RN, BSN | School Nurse
Thomas MacLaren School
1702 N. Murray Blvd.
Colorado Springs, CO 80915
nurse@maclarenschool.org
719.313.4488 | Secure Fax: 866.587.2608

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

Student's Name:_____ D.O.B._____ Grade:_____

School:_____ Teacher: _____

ALLERGY TO: _____

HISTORY:_____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
- Ask for ambulance with epinephrine
- Tell EMS when epinephrine was given

3. Stay with child and
- Call parent/guardian and school nurse
- If symptoms don't improve or worsen give second dose of epi if available as instructed below
- Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

1. Stay with child and
- Alert parent and school nurse
- Give antihistamine (if prescribed)

2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve_____minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print)_____ Phone Number: _____

Provider's Signature:_____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent:_____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a._____ 1)_____ 2) _____
   b._____ 1)_____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse:_____ Date:_____

Student Name:_____ **DOB:** _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

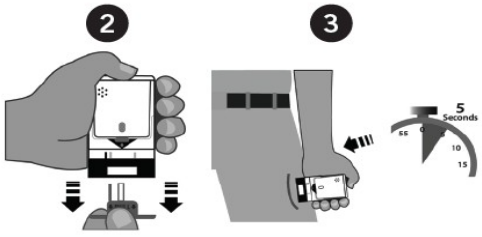
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector:_____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

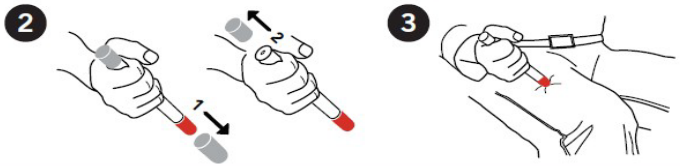
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



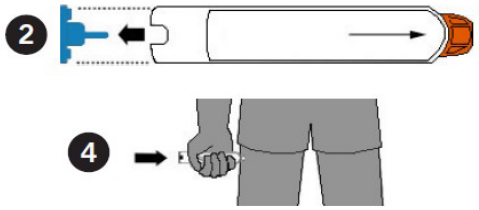
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrants meal accommodations from food service, please complete the form for dietary disability if required by

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING EPI-PEN®/ ADRENACLICK/AUVI-Q WHILE AT SCHOOL

Student Name_____ Grade _____

Date of Birth:_____ Name of Medication: _____

Life Threatening Allergy to: _____

If more than one dose is ordered, length of time between dosages of meds to be self-administered:_____

Special instructions/side effects: _____

PHYSICIAN

Physician:

- This student has demonstrated the proper use of the Epi-Pen®/Adrenaclick/Auvi-Q.
- I have instructed the student in the correct and responsible use of the medication.
- I confirm that the student is capable of administering the prescribed medications.

Physician Signature_____ Date _____

Office Phone: _____

PARENT / GUARDIAN

Parent/Guardian:

- My child has demonstrated the proper use of his/her Epi-Pen®/Adrenaclik/Auvi-Q in my presence.
- My child understands his/her allergies, symptoms, and how to properly treat them.
- I give permission for my student to keep his/her Epi-Pen®/Adrenaclik/Auvi-Q with him/her and to self-administer this medication in the school setting.
- I agree to bring an extra (back-up) Epi-Pen®/Adrenaclik/Auvi-Q to be kept in the school health offices.
- I agree to be responsible for ensuring that both the Epi-Pen®/Adrenaclick/Auvi-Q my student carries and the back-up Epi-Pen®/Adrenaclick/Auvi-Q in the school health offices have medication in them and not expired.
- I agree to regularly review with my child the proper use of his/her Epi-Pen®/Adrenaclick/Auvi-Q to include frequency of use, procedure, and documentation of usage when at school.
- I agree that Thomas MacLaren school, school employee, or school nurse is not liable for damages if there is an act of omission related to my child's use of his/her medication unless the damages were caused by the willful or wanton misconduct or disregard of the criteria of the treatment plan.

Parent Signature_____ Date _____

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING EPI-PEN®/ ADRENACLICK/AUVI-Q WHILE AT SCHOOL

STUDENT

Student:

- I agree to use my Epi-Pen®/Adrenaclick/Auvi-Q as prescribed by my doctor above. I understand my allergies, symptoms, and treatment plan.
- I agree to keep my Epi-Pen®/Adrenaclick/Auvi-Q with me at school as well as an extra one in the school health offices.
- I agree to notify the health office immediately if I administer my Epi-Pen®/Adrenaclick/Auvi-Q while at school.
- I agree never to share my Epi-Pen®/Adrenaclick/Auvi-Q with anyone.
- I understand that the freedom to manage my Epi-Pen®/Adrenaclick/Auvi-Q independently is a privilege and I agree to abide by the contract.

Student Signature_____ Date _____

SCHOOL NURSE

School Nurse:

- I agree to notify staff that have the "need to know" about this student's condition and the need to carry an Epi-Pen®/Adrenaclick/Auvi-Q-

Nurse signature:_____ Date _____

**This Health Plan and any nurse delegation related to this plan are for use during normal operation school hours. After hours, call parent(s) and/or 911 for all medical concerns/emergencies.

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING RESCUE INHALER WHILE AT SCHOOL

Student Name_____ Grade_____

Date of Birth:_____ Name of Medication: _____

If more than one dose is ordered, length of time between dosages of meds to be self-administered:_____

_____

Special instructions/side effects: _____

PHYSICIAN

Physician:

- This student has demonstrated the proper use of his/her rescue inhaler.
- I have instructed the student in the correct and responsible use of the medication.
- I confirm that the student is capable of administering the prescribed medications.

Physician Signature_____ Date _____

Office Phone: _____

PARENT / GUARDIAN

Parent/Guardian:

- My child has demonstrated the proper use of his/her rescue inhaler in my presence.
- My child understands his/her asthma triggers, symptoms and treatment plan including the difference between when to use preventive medications and his/her rescue inhaler. He/She understands the importance of letting parents and school staff know when he/she is having more difficulty than usual with his/her asthma.
- I give permission for my student to keep his/her rescue inhaler with him/her and to self-administer this medication in the school setting.
- I agree to bring an extra (back-up) rescue inhaler to be kept in the health room.
- I agree to be responsible for ensuring that both the rescue inhaler my student carries and the back-up inhaler in the health room have medication in them and not expired.
- I agree to regularly review with my child the proper use of his/her rescue inhaler to include frequency of use, procedure, and documentation of usage when at school.
- I agree to regularly review the status of my child's asthma with him/her and with his/her physician and to notify the physician when my child is having more difficulty than usual.
- I agree that Thomas MacLaren school, school employee, or school nurse is not liable for damages if there is an act of omission related to my child's use of his/her medication unless the damages were caused by the willful or wanton misconduct or disregard of the criteria of the treatment plan.

Parent Signature_____ Date _____

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING RESCUE INHALER WHILE AT SCHOOL

STUDENT

Student:

- I agree to use my rescue inhaler as prescribed by my doctor above. I understand my asthma triggers, symptoms, and treatment plan including the difference between when to use any preventive medication and my rescue inhaler.
- I agree to keep my rescue inhaler with me at school as well as an extra one in the school health room.
- I agree to go to the health office when possible to use my rescue inhaler and I agree to always go to the health office to let them know I have used it and to document each time I use my inhaler while at school.
- I agree never to share my rescue inhaler with anyone.
- I realize it is important for me to let an adult know in the school health office, as well as my parents, know if I am having more difficulty than usual with my asthma and I agree to tell them.
- I understand that the freedom to manage my rescue inhaler independently is a privilege and I agree to abide by the contract.

Student Signature_____ Date _____

SCHOOL NURSE

School Nurse

- I agree to notify staff that have the "need to know" about this student's condition and the need to carry a rescue inhaler.

Nurse signature:_____ Date _____

THOMAS MACLAREN SCHOOL

HEALTH CARE PROVIDER'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Dear Parent(s):

If you would like to have medication of **any type**, including over-the-counter medicine, given to your child during school hours, you may:

1. Come to the school and administer it to your child at the appropriate time; or
2. Discuss with your health care provider an alternative schedule to administer medications outside of school hours; or
3. Complete, in its entirety, the attached form signed by your Health Care Provider (with prescriptive authority) and by you the parent; AND
4. Provide any prescription medication in its **original labeled pharmacy container** which should include the child's name, name of medicine, specific dosage amount, and instructions for administration. For any over-the-counter medication, please provide the medicine in a **new, unopened bottle with all labels** and write the **student's full name on the bottle/container**.

Remember, staff at Thomas MacLaren School may only administer medications at school with the properly completed documentation and the medication in it's original, properly labeled container. Unfortunately, non-FDA approved substances, including herbs, supplements, essential oils, etc. cannot be administered at school.

Thank you,

Terra Fisk, RN, BSN | **School Nurse**
Phone 719.313.4488 | Secure Fax: 866.587.2608
1702 N. Murray Blvd., Colorado Springs, CO 80915

Students required to take medication(s) prescribed by a physician during regular school days may be assisted by the school nurse or other designated school personnel. Medications may be administered only if the school receives specific written instructions from the physician and parent/guardian of the student.

Authorization to Assist in Administration of Medication

Student:_____ Birthdate:_____ Grade:_____

Purpose of medication:_____ Possible Side Effects: _____

Medication:_____ Dosage: Route:_____

Time of day to be given at school: Start Date: End Date:

Asthma Inhaler / Epi-Pen (must also have self-carry contract): This student **MAY**/ **MAY NOT** carry their own Inhaler / Epi-Pen.

Physician Office Number & Fax Number:_____ Physician Signature/Stamp: _____

Parent Request that School Administer Medication

I request that medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Health Care Providers' authorization. Please give my child their medication according to the above authorization. Any special instructions are noted here: _____

It is understood that the medication is administered solely at the request of, and as an accommodation to, the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Thomas MacLaren School, the undersigned parent/guardian hereby agrees to release Thomas MacLaren School and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I will notify the school **immediately** if the medication is to be changed or terminated, or if we change health care providers.

I hereby give my permission for: (name of student)_____ to take the above-named prescription at school as ordered.

Date: _____

Parent/Guardian Signature: _____