THOMAS MACLAREN SCHOOL

HEALTH CARE PLAN INFORMATION

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 ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware ***911 may be called if a quick relief inhaler is not at school*** and my child/youth is experiencing symptoms.

Parent/Guardian Signature **Date**

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other**: _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature **Print Provider Name** **Date**

Good for 12 months unless specified otherwise in district policy.

Fax **Phone** **Email**

School Nurse/CCHC Signature **Date**

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021

Thomas MacLaren School

Health Care Provider's Authorization for the Administration of Medication by School Personnel

Dear Parent:

If your child must have medication of any type, including over-the-counter medicine , given 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 Parent; AND
4. Provide the medication in the original labeled pharmacy container which includes the child's name, name of medicine, specific dosage amount (such as 2 tabs/tsp/puffs every 4 hours - NOT a range such as 1-2 tabs/tsp/puffs every 4-6 hours), and instructions for administration. For 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 the original, properly labeled container. Non-FDA approved substances, including herbs, supplements, essential oils, etc., will NOT 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's 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 consequenc-es 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: _____

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 have 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 satus 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 fo 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 _____