Medication Administration in School or Child Care

The parent/guardian of _____ask that school/child care staff give the
(Child's name)
following medication _____at_____
(Name of medicine and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with : child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____ _____
Home Phone Cell Phone Work Phone

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name:_____ **Birth Date:**_____

Medication:_____

Dosage: _____**Route:**_____

To be given at the following time(s): _____

Special instructions: _____

Purpose of medication:_____

Side effects that need to be reported: _____

Starting Date:_____ **Ending Date:**_____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.

THANK YOU!

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.	
Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: _____

☐ **Life threatening allergy** : Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

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 physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____ _____ _____ ☐ 504 PLAN OR IEP

PARENT SIGNATURE | DATE | SCHOOL NURSE SIGNATURE | DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: _____ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between_____and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: _____ 2 puffs Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, rep eat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: C HECK APPROPRIATE BOX(ES)

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

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to us e his/her inhaler and inhaler will be kept (specify location)_____.

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE | PRINT PROVIDER'S NAME | PHONE/FAX | DATE

Copies of plan provided to: Teacher(s): ___ Phys Ed/Coach ___ Principal____ Main Office ___ Bus Driver ___ Other ____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

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

School:_____ Teacher:_____

ALLERGY TO: _____

HISTORY:_____

_____

Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

Place child's photo here

• To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy,
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling something bad is about to happen, confusion

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

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

1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. 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 **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:_____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic 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) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; 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. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date:_____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

1. _____ Room _____

2. _____ Room _____

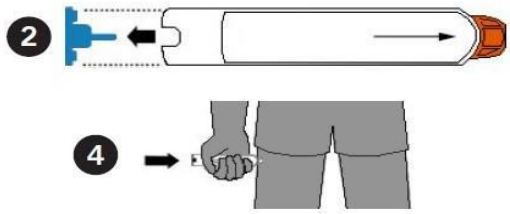
3. _____ Room _____

Self-carry contract on file: ☐ Yes ☐ No

Expiration date of epinephrine auto injector: _____

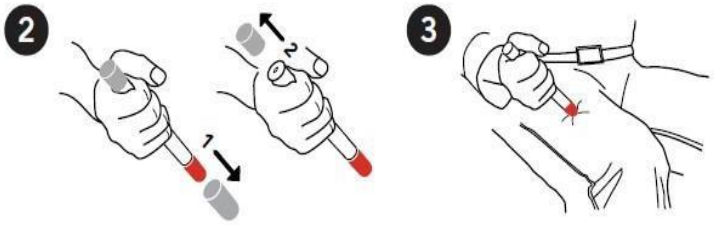
EPIPEN® AUTO-INJECTOR DIRECTIONS

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.



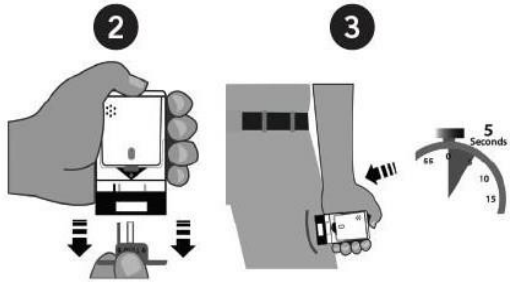
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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.



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.



NOTE: Consider lying on the back with legs elevated. Alternative positioning may be needed for vomiting (side lying, head to side) or difficulty breathing (sitting)

Additional Information