

HEALTH CARE PLAN LETTER OF EXPLANATION

Dear Parents and Guardians:

I am the School Nurse working with Thomas MacLaren School. Part of my job is to make sure that your school is up to date with state guidelines. These guidelines, set by the Colorado Department of Education, ensure that your child is as safe as possible at school.

A priority is to update our records if your child has **Asthma, Allergies, Celiac Disease, Diabetes, Migraines, Seizures or a General Health Care issue**. All forms (called Health Care Plans) must be filled out completely by either you or your health care professional **and need signatures from the Health Care Provider with prescriptive authority and the Parent/Guardian.**

All of these forms can be found on the school website: www.maclarenschool.org. From the home page click on the **Parent** tab, then scroll down the menu and click on the **Health Information** link. This will take you to the Health Page which contains links to all the necessary forms and packets.

If your child will need to carry a Rescue Inhaler, Epi-Pen®, or Diabetes supplies, then the Contract to Carry form must be completed and returned to the front desk immediately.

According to Colorado State law, we are no longer able to administer your child's emergency medication without a signed Health Care Plan and Health Care Provider's Authorization for the Administration of Medication by School Personnel. These forms can be found on our website.

Thank you for working with us to make sure that your child is as safe as possible while at school. If you have any questions, please contact me or Karen Triplett (ktriplett@maclarenschool.org).

Sincerely,

Tammie Chasteen, RN, BSN, | School Nurse
Thomas MacLaren School
1702 N. Murray Blvd.
Colorado Springs, CO 80915
719.313.4488 | Secure Fax: 866.587.2608

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) – refer to their asthma care plan
 NO

◇ STEP 1: TREATMENT ◇

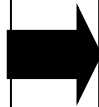
SEVERE SYMPTOMS: Any of the following:

- 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



MILD SYMPTOMS ONLY:

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



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**

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: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

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

1. _____ Room _____

2. _____ Room _____

3. _____ Room _____

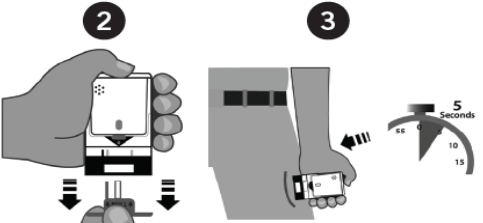
Self-carry contract on file: Yes No

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.



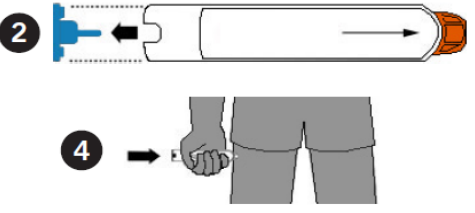
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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

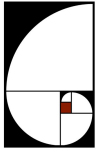
1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove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



If this conditions warrents meal accomodations from food service, please complete the form for dietary disability if required by district policy.

Additional information: _____

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



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 _____

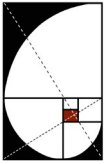
Office Phone: _____

PARENT / GUARDIAN

Parent/Guardian:

- ◆ My child has demonstrated the proper use of his/her Epi-Pen®/Adrenaclick/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®/Adrenaclick/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®/Adrenaclick/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 _____



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.