THOMAS MACLAREN SCHOOL

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

PARENT/GUARDIAN COMPLETE AND SIGN:

School/grade: _____

Child Name: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone: _____

Healthcare Provider Name: _____ Phone: _____

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

☐Life threatening allergy, specify: _____

I 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 healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, 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. I approve this care plan for my child/youth.

PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE
_____	_____	_____	_____

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:	QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: _____ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: _____

IF YOU SEE THIS:		DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request 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 ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: _____& _____	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
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 or blue • ↓ Level of consciousness • Peak flow < _____	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ 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 carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER NAME	DATE	FAX	PHONE
_____	_____	_____	_____	_____

Copies of plan provided to: ☐Teacher(s) ☐PhysEd/Coach ☐Principal ☐Main Office ☐Bus Driver Other_____

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 _____

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 and all homeopathics, 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 AND
4. Provide the medication in the original labeled pharmacy container which includes the child's name, name of medicine, dosage amount, and instructions for administration. For over-the-counter medication, please provide the medicine in a new, unopened bottle with all labels.

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.

Thank you,

Tammie Chasteen, 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: _____