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

THOMAS MACLAREN SCHOOL

CELIAC HEALTH CARE PLAN

Student's Name: _____ DOB: _____
School: _____ Grade: _____
Parent/Guardian: _____
Home Phone: _____
Dad's Cell Phone: _____ Dad's Work Phone: _____
Mom's Cell Phone: _____ Mom's Work: _____
Emergency Contact: _____ Phone: _____
Physician: _____ Phone: _____

HISTORY: _____ has Celiac Disease, chronic autoimmune disease characterized by intestinal malabsorption of virtually all nutrients and precipitated by eating gluten-containing foods. _____ diet also need to be casein, nut and legume free.

PLAN OF CARE FOR CELIAC DISEASE:

Signs to watch for during school:

1. **Stomach ache, stomach cramps**
2. **Diarrhea**
3. **Abdominal pain**

The Classroom Teacher will:

1. **Confer with parent before any food is given in class, i.e. Birthday treats, holiday treats, etc**
2. **Confer with parent for food substitutes to use in food projects**
3. **Make sure _____ washes hands thoroughly after handling play-doh or any other substance he/she touches in class that could cause Celiac Disease to flare.**
4. **Immediately send _____ to the office if he/she has an accidental ingestion.**

The Health Room personnel will:

1. **Immediately call parent if _____ arrives in the office.**
2. **Report any symptoms of abdominal pain, diarrhea, rash or unusual behavior to parent. Parent will determine if medications need to be given.**

The Parent will:

1. **Be responsible for immediate care of any problems**
2. **Keep school staff updated with any changes or care needed.**
3. **Provide medications with proper paperwork completed.**

Parent's Signature	**Date**	**Nurse's Signature**	**Date**
Teacher's Signature	**Date**	**Physician Signature**	**Date**

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

List of foods that contain gluten.

Foods made from grains that contain harmful gluten include:

Wheat and any ingredient with wheat in its name (except buckwheat, which is gluten free)
Wheat flour (white, all purpose)
Rye
Barley
Oats (not considered safe due to cross contamination)
Malt and malt flavoring, syrup, and extract (usually made from barley)
Malt vinegar
Kamut
Triticale
Spelt
Durum
Farina
Einkorn
Semolina
Bulgar
Cake flour
Matzo
Matzah
Couscous
Wheat starch
Hydrolyzed vegetable protein
Most soy and teriyaki sauces
Licorice
Nuts (if they are flavored or roasted with a gluten-containing ingredient)
Modified food starch could be modified wheat starch. Most of the modified food starch used in the US is modified cornstarch.
Dextrin (which is rare, could be made from wheat)
Processed cheese may contain gluten
Real cheese coated with wheat to prevent caking
Seasoning and seasoning mixes need to be checked to be sure they are gluten free (plain spices are gluten free)
Flavorings could include gluten in the form of barley or malt. Wheat should be labeled now as an allergen.

Safe foods include foods made from grains that do not contain harmful gluten:
Corn, rice, amaranth, buchwheat (kasha), montina, millet, quinoa, tef, sorghum, and soy.
Plain fruits and vegetables
Plain meat, seafood, and eggs,
Plain nuts, beans, and legumes, and flours made from them
Potato/potato starch
Tapioca
Arrowroot.

Safe foods could be cross-contaminated by gluten in certain settings (i.e. buffet line, toasters, contaminated hands touching safe food…)

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: _____