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

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.		Place child's photo here
Child Name:	Birth date:	
Parent/Guardian Contact:	Phone:	
Emergency Contact:	Phone:	
School:	Grade:	

Triggers: ☐ tiredness ☐ flashing lights ☐ illness ☐ hunger ☐ temperature ☐ Other**:** _____
Seizure Aura (if any):_____
Seizure history: ☐ Convulsive ☐ Focal ☐ Absence Date of last known seizure _____
Describe:_____

Antiseizure Medication Taken at Home	**Common side effects**

Other Seizure Treatments/Special Diet Therapy:

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 devices. I approve this Seizure Emergency Care Plan for my child.

_____ _____ _____ _____ ☐ 504 plan
PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE ☐ IEP

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

IF YOU SEE THIS:	**DO THIS:**
☐ **Convulsive Generalized Tonic Clonic**: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. **Administer rescue treatments as marked below.**
☐ **Focal**: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes.These seizures usually last 1-2 minutes.	1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. **6. Administer rescue treatments as marked below.**
☐ **Absence**: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

Rescue Treatments

☐ Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops. Give rescue medications below if seizure does not stop within _____minutes.

If seizure lasts longer than ___ minutes administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If cluster of ___ or more seizures in _____ min administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If emergency medication is administered: ☐ Call 911 immediately or ☐ Call 911 if seizure does not stop within 5 minutes

Other:

If no emergency medication is at school and the child is experiencing seizures:
Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

_____ _____ _____ _____
HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX 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 , 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,

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: _____