THOMAS MACLAREN SCHOOL

HEALTH CARE PLAN INFORMATION

Dear Parents and Guardians:

Welcome to the 2023-2024 school year at Thomas MacLaren School! Every year it is helpful for us to have an update to our records if your student has asthma, allergies, celiac disease, diabetes, migraines, seizures or any other health care issue. This allows us to better care for your student throughout the school year and helps decrease the number of interruptions to their learning due to illness or complications from their health concerns.

All of the forms included in these health care plans (HCPs) must be filled out completely by either you or a health care provider with prescriptive authority. Please note that **both** the parent/guardian and the health care provider need to sign the documents. Unfortunately, we are not able to administer your student's emergency medication without a signed HCP and a completed *Authorization for the Administration of Medication by School Personnel*

If your student will need to carry a rescue inhaler, Epi-Pen®, or diabetes supplies with them this year, then please fill out the *Contract to Carry* form and return to the front desk prior to sending your student to school with their medication.

For your reference, all of the links for these forms and packets can be found on the school website: www.maclarenschool.org under the **Parent** tab in the **Health Information** section.

Thank you for letting us partner with you to make sure that your student has a healthy and safe school year. If you have any questions or concerns, please don't hesitate to contact me.

Kind Regards,

Terra Fisk, RN, BSN | School Nurse
Thomas MacLaren School
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Colorado Springs, CO 80915
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Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

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

School:_____ Teacher: _____

ALLERGY TO: _____

HISTORY:_____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

◊ STEP 1:

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,

→

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**

MILD SYMPTOMS ONLY:
NOSE: Itchy, runny nose, sneezing SKIN: A few hives, mild itch

→

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. I understand that this health plan and any Nurse delegation related to this plan are for use during normal operational school hours. After hours staff/coaches will call parent(s) and/or 911 for all medical concerns/emergencies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse:_____ Date:_____

Student Name:_____ **DOB:** _____

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

1._____ Room _____

2._____ Room _____

3._____ Room _____

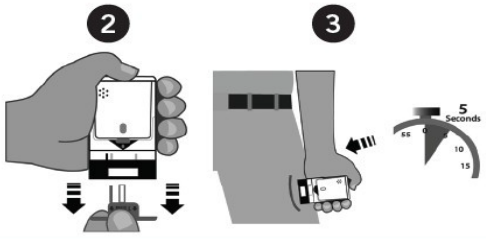
Self-carry contract on file: ☐Yes ☐No

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.

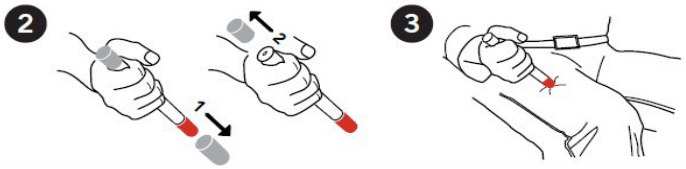
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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.



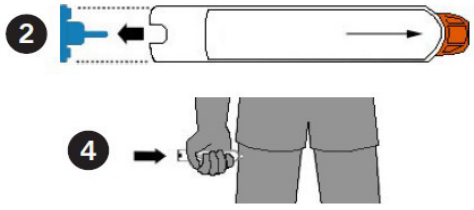
ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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 warrants meal accommodations from food service, please complete the form for dietary disability if required by

Additional information:_____

_____

_____

_____

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

THOMAS MACLAREN SCHOOL

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®/Adrenaclik/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®/Adrenaclik/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®/Adrenaclik/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 _____

THOMAS MACLAREN SCHOOL

CONTRACT FOR STUDENTS CARRYING EPI-PEN®/ ADRENACLICK/AUVI-Q WHILE AT SCHOOL

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.