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
1702 N. Murray Blvd.
Colorado Springs, CO 80915
nurse@maclarenschool.org
719.313.4488 | Secure Fax: 866.587.2608

THOMAS MACLAREN SCHOOL

GENERAL HEALTH CARE

Name_____Birthdate_____Grade_____
Teacher_____ School_____ Date_____
Physician_____Phone_____
Parent_____ Phone(s)_____
Medications taken at home_____
Medications taken at school_____
(Include dosage and frequency. If "as needed," also indicate how frequently medication may be repeated.)

Health condition or diagnosis_____

_____

Symptoms may include_____

_____

_____

Medical Action Plan and/or Academic Accommodations:

_____

_____

_____

Starting Date: _____ Ending Date:_____

**I give my permission for the information on this Health Care Plan to be shared with adults in the school setting that will be working with my child on a need-to-know basis, including Transportation.
**This Health Care Plan will remain in effect for the current school year.
**It is the responsibility of the parent to notify the school nurse whenever there is a change in the student's health status or care.
**This Health Care Plan and any nurse delegation related to this plan are for use during normal operational school hours. After hours, call 911 and parent(s) for any medical emergencies or concerns.

Parent_____Date_____

Physician_____Date_____

School Nurse_____Date_____

rev. 04-13-2020

****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.**

THOMAS MACLAREN SCHOOL

HEALTH CARE PROVIDER'S AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Parent/Guradian:

If your child must have medication of any type, **including over-the-counter medicine** , given during school hours, you may:

- Come to the school and administer it to your child at the appropriate time; **or**
- Discuss with your health care provider an alternative schedule to administer medications outside of school hours; **or**
- Complete, in its entirety, the attached form **signed by your Health Care Provider (with prescriptive authority) and by you the parent/or guardian**; and
- **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.

Kind Regards,

Terra Fisk, 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:_____

Medication:_____ Purpose of Medication: _____

Possible Side Effects: _____ Dosage: _____Route: _____

Start Date:_____ End Date:_____

Time of day to be given at school: _____

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 Provider'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 consequences 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: _____