GENERAL MEDICATION AND ALLERGY AND ANAPHYLAXIS ACTION PLAN and ASTHMA INSTRUCTIONS

Colorado state legislation requires that strict and specific documentation and practices must be in place before _____ can administer any medication to your child, for both prescribed and over-the-counter medications. A **"prescribed"** medication is one that you must buy from a pharmacist with a prescription from a physician, for example EpiPens and Albuterol. An **"over-the-counter"** medication can be purchased without a physician's prescription, for example, Tylenol and Benadryl.

Parents and Physicians please read these instructions carefully!

1. The form must be completely filled out, including the reason for the medication. Physician, please fill out every line.
2. The form must be signed by BOTH the parent and the prescribing physician.
3. Please have the tittle of the individual who is writing the orders after the name, example MD
4. The medication provided to the school must be EXACTLY what is listed on the form. For example, if your form says "Benadryl 1 tsp", you cannot provide a generic brand. Tell your physician what you will be providing – brand name or generic - so the form will be filled out correctly. **Diphydramine HCL needs to written on all generic requests the words generic medication is not sufficient enough.**
5. The medication provided must be in the same "form" as what is listed on the plan. For example, if your plan says "chewable tables", you must give us chewable tablets.
6. If the physician writes medication in **mg per dose** parents can bring in liquid, chewables, quick strips etc.
7. You can only give us one "form" of the medication; you cannot give us both chewables and liquid antihistamine, for example.
8. Staff are not allowed to cut any pills. If physician orders 6.25mg of Benadryl than liquid Benadryl will need to be given to the program. The staff can not cut a 12.5mg tablet in half.
9. If there are specific instructions for the administering of a medication - for example, given with food – the instructions must be written on the plan by the prescribing physician. It cannot be changed by the parents.
10. The medication has to be in the original container and ALL prescription medications (as opposed to over-the-counter medications) must have the original prescription label on them and be in the original container. Please note this is especially true for EpiPens and inhalers. They must have the labeled box or the pharmacy label must be on the plastic container. You can ask the pharmacy to label the plastic container.
11. Parents must provide a calibrated measuring device, such as a calibrated oral syringe, spoon, or cup, for the medication to be given in. The spoon, cup, syringe MUST have a factory-marked indication for the dosage amount prescribed on the form. For example, if the prescribed dosage on the plan says "1/2 tsp", there MUST be a factory-marked line that reads "1/2 tsp". We cannot "eyeball" amounts.
12. The dates that the forms are signed are good for one year if the child is over 2 years of age. If under 2 years of age only good for every well baby check up.
13. Instructions and information on the forms should be in "lay" terms for non-medical people. Example: **as needed every 4 hours for temperature of 100 degrees.**
14. "As needed" and /or "PRN" by itself will not be allowed.

15. If the form indicates that a 2nd dose of Epipen be given, please provide us with 2 EpiPens. Please note: once we have given your child one EpiPen, we will call 911. The average time for 911 to arrive is around 8 minutes.
16. Expiration dates must be followed we are not allowed to give expire medication. If medication date states the medication expires on 9/2011 we can give the medication thru the month of September and on October first we cannot dispense the medication anymore / CANNOT TAKE Generic Epinephrine unless it's Mylan (Generic)

Please don't hesitate to call us with ANY questions about medications. Our goal is to keep your child safe!

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ Birthdate: _____

Medication: _____

Dosage: _____ Route _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

Name the MD DO & DDS - PA-C DMP(Foot) CNP CFNP CPNP

_____ _____
Phone Number Date

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.
Thank you!

NOT For: Inhaler, Epinephrine or Antihistamine

For: Inhaler + Nebulizer Asthma

PARENT/GUARDIAN complete and sign the top portion of form.

Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

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

☐ **Life threatening allergy :** Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

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 physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____ _____ _____ ☐ 504 PLAN OR IEP

PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

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

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: _____ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

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

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE

Copies of plan provided to: Teacher(s) Phys Ed /Coach Principal Main Office Bus Driver Other

Allergy & Anaphylaxis Action Plan

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

Place child's photo here

To be completed by healthcare provider

ALLERGY TO: _____
History: _____
Asthma: ☐YES ☐NO *Higher risk for severe reaction

◊ STEP 1: TREATMENT

SYMPTOMS: GIVE CHECKED MEDICATION(S)			
➢Suspected ingestion or sting, but *no symptoms*		☐Epinephrine	☐Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort			☐Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth		☐Epinephrine	☐Antihistamine
SKIN: Flushing, hives, itchy rash		☐Epinephrine	☐Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea		☐Epinephrine	☐Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough		☐Epinephrine	☐Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing	☐ Inhaler	☐Epinephrine	☐Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin		☐Epinephrine	☐Antihistamine
➢If reaction is progressing (several of the above areas affected), give		☐Epinephrine	☐Antihistamine

Potentially life threatening: give epinephrine first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly (check one):
☐EpiPen®0.3 mg ☐EpiPen®Jr.0.15 mg ☐ Auvi Q 0.3mg ☐ Auvi Q 0.15mg
☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give _____ (medication/dose,mg /route

****IF ANTIHISTAMINE HAS BEEN GIVEN, PARENT MUST BE NOTIFIED AND STUDENT PICKED UP FROM SCHOOL****

Asthma Rescue (if asthmatic): give _____
(medication/dose,puffs/route)

Provider (print) _____ Phone Number: _____ Fax _____

Provider's Signature: _____ Start Date: _____ End Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic 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) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; 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. I approve this Severe Allergy Care Plan for my child. **This Health Care Plan will be effective for one school year.**

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

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REFUSAL TO PROVIDE MEDICATION FORM

SCHOOL/DAYCARE/CAMP PROGRAM SITE: _____

From: _____
(parent/guardian name)

Regarding: _____ Date of Birth: _____
(child's name)

When I enrolled my child at your school/site, I informed you that my child has the following medical condition _____. However, at this time I do not wish to supply you with any medication for the above-mentioned condition and I take full responsibility for any reactions or problems related to my child's condition while he/she is in your care. I acknowledge that I have been informed that if any emergency situation occurs, 911 will be called to provide care for my child. I also understand that if 911 is called, I am financially responsible for any bills incurred.

I have reviewed this with my child's medical care provider and their signature is below to concur with my decision in regards to my child's medical condition.

***Parent/Guardian Signature:	Date:
Parent/Guardian Printed Name:	
***Signature of Health Care Provider:	License Number:
Health Care Provider Printed Name:	
Phone Number:	Date: