ASTHMA CARE PLAN

ALLERGY AND ANAPHYLAXIS ACTION PLAN and ASTHMA INSTRUCTIONS

Colorado state legislation requires that strict and specific documentation and practices must be in place before Kids Adventures 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. 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.**
4. 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.
5. If the physician writes medication in **mg per dose** parents can bring in liquid, chewables, quick strips etc.
6. You can only give us one "form" of the medication; you cannot give us both chewables and liquid antihistamine, for example.
7. 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.
8. The medication has to be in the original container (box) 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. 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.
9. 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.
10. 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.
11. 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.**
12. "As needed" and /or "PRN" by itself will not be allowed.
13. If you give us 2 EpiPens, the Allergy Form must have instructions for how and when to use the 2nd Epipen. If it does not, please do not give us two. If the form indicates that a 2nd dose be given, please provide us with 2 EpiPens. Please note: once we have given your child one EpiPen, we will call 911. Theoretically, an ambulance will arrive before the 2nd dose is to be administered.

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14. 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

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

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Medication Administration in School

The parent/guardian of _____ **ask that the school 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 school 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, 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 the 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. *The first dose of any medication should be administered at home prior to sending it to school.*

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

_____ _____
Work Phone Home Phone

Health Care Provider Authorization to Administer Medication in School

Child's Name: _____ **Birthdate:** _____

Medication: _____ **Dosage:** _____

Route: _____ **To be given at the following times(s):** _____
May repeat medication every _____ **hours**

Purpose of Medication: _____

Special instructions (storage, may student carry med, etc.): _____

_____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of HCP with Prescriptive Authority **License Number**

_____ _____

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

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Photo of Child

COLORADO SCHOOL ASTHMA CARE PLAN:

NAME:	BIRTH DATE:
TEACHER:	GRADE:
PARENT/GUARDIAN:	CELL PHONE:
HOME PHONE:	WORK PHONE:
OTHER CONTACT:	PHONE:
PREFERRED HOSPITAL:	

Triggers: ☐ Weather(cold air, wi☐) Illn☐ss Ex☐cise ☐Smoke ☐ Dog/☐at D☐st Mold Pollen
Other:_____
☐Give 2 puffs of _____rescue m☐d 15 minutes before activity. Ind☐ations: Phy☐Ed class exe☐ise/ sports Recess
Explanation:
☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK - UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)	
IF YOU SEE THIS:	**DO THIS:**
• Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other:	• Stop physical activity • **GIVE RESCUE MED (NAME):_____** **1 PUFF 2 PUFFS OTHER: VIA SPACER** • If no improvement in 10-15 minutes, repeat use of rescue med: **1 PUFF 2 PUFFS OTHER: VIA SPACER** • If student's symptoms do not improve or worsen, call 911 • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better
• **IF THERE IS NO RESCUE INHALER AT SCHOOL:** ➢ 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	
IF YOU SEE THIS: RED ZONE	**DO THIS IMMEDIATELY:**

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• Coughs constantly • Struggles or gasps for breath • Trouble talking (only able to speak 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓Level of consciousness	• **GIVE RESCUE MED (NAME):_____** **1 PUFF 2 PUFFS OTHER: VIA SPACER** • Repeat rescue med if student not improving in 10-15 minutes • 911 Inform attendant the reason for call is ASTHMA • Call parents/guardians and school nurse • Encourage student to take slower deeper breaths • Stay with student and remain calm • *School personnel should not drive student to hospital*

INSTRUCTIONS FOR RESCUE INHALER USE: HEALTH PROVIDER: PLEASE 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

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

☐ Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located:

☐ Student has life threatening allergy, the EpiPen is located:

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDERS NAME START DATE END DATE

Fax number_____ Phone Number_____

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.

_____ _____ _____ _____

PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

Copy of plan provided t☐ Teach☐s Phys Ed/C☐ach Pr☐cipal Ma☐Office ☐us Driver Otl☐

504 Plan or IEP