COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN:

Child Name: ______________________ School/grade: ______________________

Parent/Guardian Name: ______________________ Birthdate: ______________________

Phone: ______________________

Healthcare Provider Name: ______________________ Phone: ______________________

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

☐Life threatening allergy, specify: ______________________

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE ______________ DATE ______________ NURSE/CCHC SIGNATURE ______________ DATE ______________

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:		QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: __________ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: __________
	IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: ______ & ______	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • ↓ Level of consciousness • Peak flow < ______	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

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

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

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

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE ______________ PRINT PROVIDER NAME ______________ DATE ______________ FAX ______________ PHONE ______________

Copies of plan provided to: ☐Teacher(s) ☐PhysEd/Coach ☐Principal ☐Main Office ☐Bus Driver Other__________

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: ______________________ D.O.B. ________ Grade: ________

School: ______________________ Teacher: ______________________

ALLERGY TO: ______________________

HISTORY: ______________________

____

To be completed by healthcare provider

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

◊ STEP 1: TREATMENT

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, Confusion, agitation

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 epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort

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.

Parent/Guardian's Signature: ______________________ Date: ________

School Nurse: ______________________ Date: ________

Student Name: ______________________________ **DOB:** ______________________

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

1.______________________________ Room ______________________

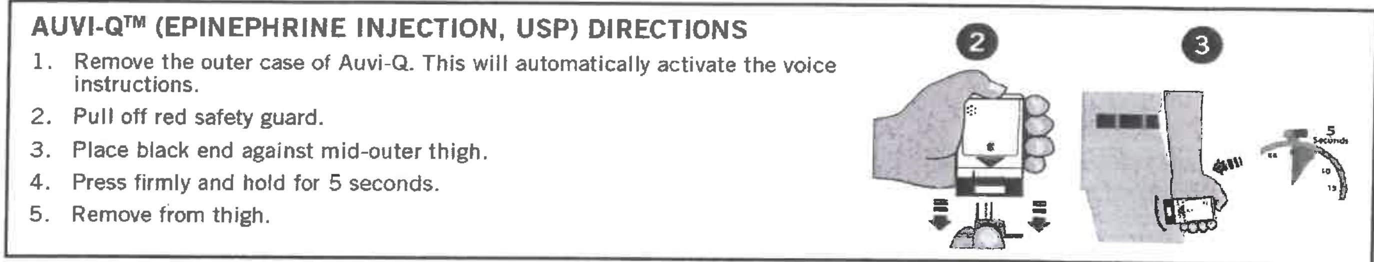
2.______________________________ Room ______________________

3.______________________________ Room ______________________

Self-carry contract on file: ☐Yes ☐No

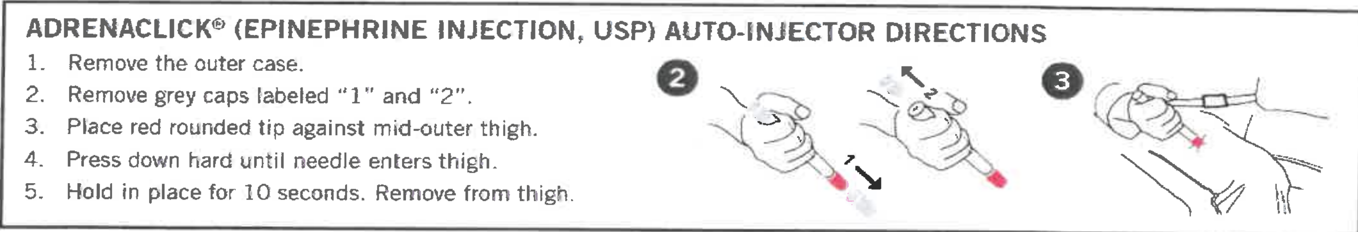
Expiration date of epinephrine auto injector: ______________________

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.



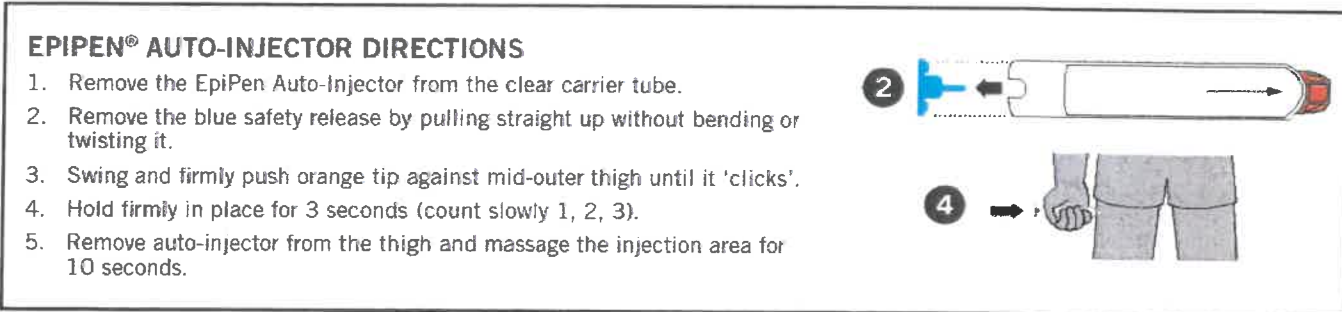
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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 warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:____

____

____

____

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

CONTRACT FOR STUDENTS CARRYING INHALERS WITH THEM WHILE AT SCHOOL

STUDENT

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature ______________________________ Date ____________________ ______________

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the treatment plan.

Parent's Signature ______________________________ Date ____________________

SCHOOL NURSE

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

Registered Nurse's Signature ____________________ Date ____________________

CONTRACT FOR STUDENTS CARRYING EPI-PENs WITH THEM WHILE AT SCHOOL

STUDENT

- ☐ I plan to keep my Epi-pen with me at school rather than in the school health office.
- ☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office immediately if my Epi-pen has been used.
- ☐ I will not allow any other person to use my Epi-pen.

Student's Signature ______________________________ Date ____________________

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
- ☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the treatment plan.

Parent's Signature ______________________________ Date ____________________

SCHOOL NURSE

- ☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

Registered Nurse's Signature ____________________ Date ____________________

Individualized Health Plan: Diabetes in School Setting Date of Plan: ____

To be completed by School Nurse in consultation with Parent, School staff and per HealthCare Provider Orders
See Colorado Diabetes Standard of Care Guidelines for the School Setting

Student: ______ **DOB:** ____ **Preferred Tel#:** ________
School: ____ Grade: ____ Teacher: ____

Health Concern: ☐ Type 1 Diabetes ☐ Type 2 Diabetes Other: ____
Date of Diagnosis: ____
Mother: ____ Work: ____ Cell Phone: ____
Father: ____ Work: ____ Cell Phone: ____ (circle all preferred contact phone #s)
Guardian: ____ Phone: ____
School Nurse: ____ Phone: ____
Physician: ____ Phone: ____ Fax: ____ Date of Orders: ____
Diabetes Educator: ____ Phone: ____ Fax;
Hospital of Choice: ____ 504 on file at School: ☐ Yes ☐ No

Target Range Blood Glucose Range ____ mg/dl to ____ mg/dl
Notify Parents if Blood Glucose values below ____ mg/dl or greater than ____ mg/dl

Medications:

Insulin Delivery Device: ☐ Insulin Pen ☐ Insulin Pump ☐ Syringe & vial Insulin Type: ____
Insulin Dosing – *see Insulin Injection Administration or Pump Administration Addendum*
☐ Parent/guardian elects to give insulin needed at school Notify parent/guardian for correction if Blood Glucose ≥ ____
Glucagon: Dose: ____ **mg** **Intramuscular** in ☐ Arm ☐ Buttock ☐ Thigh – *See Severe Hypoglycemia Care

Required Blood Glucose Monitoring at School *(See Blood Glucose Treatment Plan)*

Where to check Blood Glucose ☐ Health Room ☐ Classroom Other: ____
☐ Student can carry supplies and test where needed and when needed
☐ Continuous glucose monitoring: Always *Confirm glucose level with a fingerstick/meter prior to treatment*
Alarms set for: Low: ____ mg/dl High: ____ mg/dl

When to Check Blood Glucose

☐ As needed for signs/symptoms of low/high blood glucose and/or does not feel well
☐ Before School Program ☐ Before Snack ☐ Mid-Morning ☐ After School Program
☐ Before Lunch ☐ After lunch ☐ Recess ☐ Before PE ☐ After PE
☐ Extra-curricular activity ☐ Behavioral Concern ☐ 2.5 Hours after Correction
☐ School Dismissal ☐ Before Riding Bus/Walking home ☐ Other: ____

Student's Schedule

Lunch ____ PE ____ Recess ____ Snack ____ (am) ____ (pm)
Location of Snacks: ____ **Location Eaten:** 11

Student's Self Care (ability level to be determined by School Nurse and Parent with input from Health Care Provider prn)

Totally Independent Management	☐ Yes	☐ No
Assist/supervise blood glucose testing by trained staff	☐ Yes	☐ No
Blood glucose testing to be done by trained staff	☐ Yes	☐ No
Administers Insulin Independently	☐ Yes	☐ No
Insulin injections to be done by trained staff	☐ Yes	☐ No
Self-Injects with verification of dose & supervision	☐ Yes	☐ No
Monitors own snack and meals	☐ Yes	☐ No
Trained staff to monitor food intake	☐ Yes	☐ No
Independently Counts Carbs	☐ Yes	☐ No
Trained staff to assist with carb counting	☐ Yes	☐ No
Self-treats mild hypoglycemia	☐ Yes	☐ No
Tests and interprets urine/blood ketones	☐ Yes	☐ No

Other: ____
*See Pump Addendum for self-care pumps skills

Additional Information

☐ Section 504 Plan Completed on: ____ ☐ Agreement for Student's Independent Management Completed on ____

Standardized Academic Testing Procedures: Notify Parents and School Nurse of upcoming standardized testing in order to create a plan for Blood Glucose monitoring and treatment.

Classroom Emergency Preparedness: ☐ Snacks/Water in Student's Classrooms (provided by parent)
Supplies to be kept: *Indicate location(s)* ____

Staff trained	**Monitor blood glucose/treat hypo/hyperglycemia**	**Give insulin**	**Give Glucagon**
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐
4. _____	☐	☐	☐

Field Trip Information and Special Events:

1. Notify parent and school nurse in advance so proper training can be accomplished
2. Adult staff must be trained and responsible for student's needs on field trip
3. Extra snacks, BG meter, copy of health plan, glucagon, insulin & emergency supplies must accompany student on field trip
4. Adult(s) accompanying student on a field trip will be notified of student's health accommodations on a need to know basis

Class/School Parties or Events with Food

☐ In the event of a class party may eat the treat and insulin coverage per orders
☐ Student able to determine whether to eat the treat
☐ Replace with parent supplied treat ☐ may NOT eat the treat ☐ Contact parent prior to event

Exercise and Sports

☐ Snack prior to PE ☐ Snack after PE ☐ Snack before Recess ☐ Snack after Recess #of Snack Carbs: ______
In general, there are no restrictions on activity unless specifically noted.
A student should not exercise if his/her blood glucose is < ______mg/dL or > 300 mg/dL (with positive ketones) immediately prior to exercise or until hypoglycemia/hyperglycemia is resolved.
A source of fast-acting glucose & glucagon should be available in case of hypoglycemia.

Further Instructions/Comments: ____

See Addendum (s):

☐ Emergency Action Plan: Glucose Monitoring & Treatment ☐ Insulin Injection and Medication Management
☐ Continuous Glucose Monitor ☐ Insulin Pump ☐ Supplies

PARENT/GUARDIAN PERMISSION

I understand that:

- Medication orders are valid for this school year only & need to be renewed at the beginning of each school year.
- New Physician Orders are needed when there are any changes in the medication orders. (e.g. at quarterly clinic visits)
- Medication orders will become part of my child's permanent school health record.
- Medications must be in original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for notifying the school nurse of any changes in Medication or care orders.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I give permission to the school nurse to contact the above health care provider for information relevant to the prescribed medication administration, provider orders, and related student health information appropriate for my child's health and safety.
- I give my permission to the school nurse and designated staff to perform and carry out the diabetes tasks as outlined in this Individualized Health Plan (IHP).
- I understand that the information contained in this plan will be shared with school staff on a need-to-know basis.
- Parents/Guardian and student are responsible for maintaining necessary supplies, snacks, blood glucose meter, medications and other equipment.

Parent Name: ____________ Parent Signature: ____________ Date: ____

School Nurse: ____________ School Nurse Signature: ____________ Date: ____________

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol

(Check all that apply and clarify below)

- ☐ Contact school nurse at ______________________
- ☐ Call 911 for transport to ______________________
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other ______________________

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature ______________________ **Date** ______________

Parent/Guardian Signature ______________________ **Date** ______________