



Belle Creek Charter School

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www.BelleCreekCS.org

School Year: _____

Medication Administration Authorization

The parent / guardian of _____ asks 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.

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 original container.

The Program agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff.

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 Cell Phone

Health Care Provider Authorization

Child's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____

Purpose of Medication: _____ Route: _____

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

Special Instructions: _____ Side Effects to be Reported:

Starting Date: _____ Ending Date: _____

Signature of Health Care Provider with Prescriptive Authority License Number

Print Name of Health Care Provider Phone Fax Number

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

.....
Copied information onto Medication Log _____
Staff Signature Date

Allergy & Anaphylaxis Action Plan

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

Place child's
photo here

ALLERGY TO: _____

History: _____

Asthma: YES (Higher risk for severe reaction) NO

◇ STEP 1: TREATMENT ◇

To be completed by healthcare provider

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

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!

Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): **0.3 mg** **0.15 mg**

Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give _____
(medication/dose/route)

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

Student has been instructed and is capable of 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 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.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ DOB: _____

TRAINED STAFF MEMBERS

1. _____
2. _____
3. _____
4. _____
5. _____

- Room _____
 Room _____
 Room _____
 Room _____
 Room _____

Self-carry contract on file. Yes No

Medication located in: _____

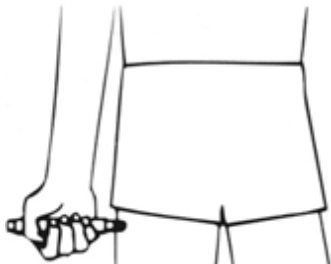
EpiPen® and EpiPen® Jr. Directions

Expiration date: _____

- Pull off blue activation cap.



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Expiration date: _____

- Remove caps labeled "1" and "2."

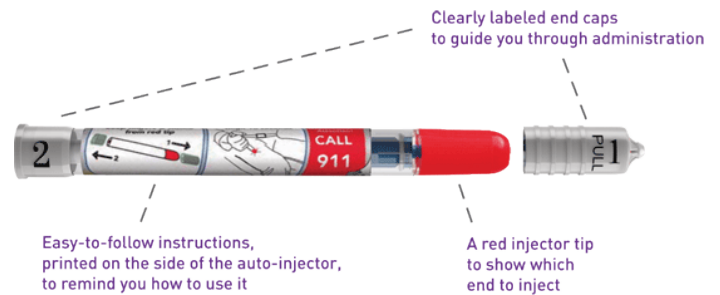


- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



Adrenalick 0.3 mg. and Adrenalick 0.15 mg. Directions

Expiration date: _____



Once epinephrine is used, call 911. Student should remain lying down.

Additional information: _____

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, wind) Illness Exercise Smoke Dog/Cat Dust Mold Pollen

Other: _____

Location of medication: school office student possession at all times other location (list) _____

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider please complete section)

Give 2 puffs of quick relief med (*name*) _____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/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 quick relief med)

IF YOU SEE THIS:	DO THIS:
<ul style="list-style-type: none"> ▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other: 	<ul style="list-style-type: none"> ▪ Stop physical activity ▪ Give quick relief med (<i>name</i>): _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With mask <input type="checkbox"/> other: _____ ▪ If no improvement in 10-15 minutes, repeat use of rescue med: <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With mask <input type="checkbox"/> other: _____ ▪ 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 quick relief 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

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for quick relief med)

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (can speak only 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness 	<ul style="list-style-type: none"> ▪ Give quick relief med (<i>name</i>): _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With mask <input type="checkbox"/> other: _____ ▪ Repeat quick relief med if student not improving in 10-15 minutes <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With mask <input type="checkbox"/> other: _____ <input type="checkbox"/> Refer to anaphylaxis plan if student has life threatening allergy. ▪ Call 911 Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ <i>School personnel should not drive student to hospital</i>

INSTRUCTIONS for QUICK RELIEF 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.

Student has life threatening allergy, refer to anaphylaxis plan.

 HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER'S NAME DATE
 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 504 Plan or IEP

Copies of plan provided to: Teachers ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____