



Belle Creek Charter School

9290 E. 107th Ave. Henderson, CO 80640

(303) 468-0160 + FAX (303) 468-0164

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 and Anaphylaxis Action Plan and Medication Orders

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 ◇

SEVERE SYMPTOMS:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain



1. INJECT EPINEPHRINE IMMEDIATELY

2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
 - Antihistamine
 - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. GIVE ANTIHISTAMINE

2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using auto-injector (check one): 0.3 mg 0.15 mg

Administer 2nd dose if symptoms do not improve in _____ minutes

Antihistamine: (brand and dose) _____

If Asthmatic: (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: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◇ 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: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

TRAINED/DELEGATED STAFF MEMBERS

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

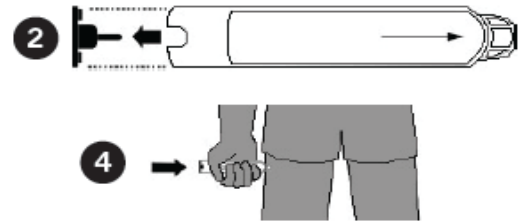
- Room _____
- Room _____
- Room _____
- Room _____
- Room _____

Self-carry contract on file. Yes No

Medication located in: _____

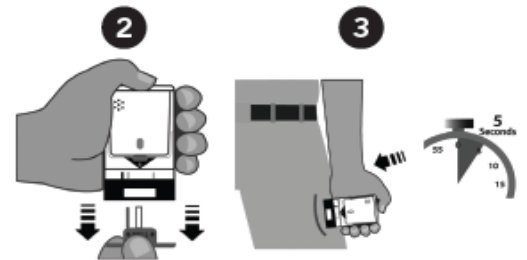
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

- 1. Remove the EpiPen Auto-Injector from the plastic carrying case.
- 2. Pull off the blue safety release cap.
- 3. Swing and firmly push orange tip against outer thigh.
- 4. Hold for approximately 10 seconds.
- 5. Remove and massage the area for 10 seconds.



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 outer thigh.
- 4. Press firmly and hold for 5 seconds.
- 5. Remove from thigh.



ADRENACLICK™/ADRENACLICK™ GENERIC DIRECTIONS

- 1. Remove the outer case.
- 2. Remove grey caps labeled "1" and "2".
- 3. Place red rounded tip against outer thigh.
- 4. Press down hard until needle penetrates.
- 5. Hold for 10 seconds. Remove from thigh.



**Once epinephrine is used, call 911.
Student should remain lying down or in a comfortable position.**

Additional information: