## If Your Child Requires Medication While at Camp:

- ✓ All prescription and nonprescription medication given in child care, camp or school settings require a **written authorization** from your health care provider, as well as parent written consent (see form). This is a licensing requirement. The medication authorization forms are available from the center.
- ✓ The instructions from your health care provider must include information regarding the medication, reason for the medication, the specific time of administration and the length of time the medication needs to be given. All medication must be brought in the original labeled container. *Note: Medication prepared in a bottle or "cup" may not be left with program staff. Vitamins are considered like any other medication, please do not leave them with your child.*
- ✓ Program staff involved in medication administration receives special training and is supervised by a nurse consultant.
- ✓ Program staff is not authorized to determine when an "as needed" medication is to be given. Specific instructions are necessary.
- ✓ Children with chronic health conditions (such as: asthma, diabetes, severe allergies and seizure disorders) require a detailed health plan (see form) to be developed in collaboration with the consulting registered nurse.

**Self-Carry Policy**

- ✓ In Colorado, children may be allowed to self-carry asthma and anaphylaxis medications in school as well as some group care settings. Typically this medication is not handled by school or child care personnel nor stored in the program's medication storage area. In order to self-carry any medicine it is required that an "Authorization to Administer Medication at School" form AND a "Contract to Self-Carry" form both be completed by the student's physician, parent/guardian, and the student.

Factors to consider before allowing your children to self-carry:

Student Factors:

- ✓ Desire to carry and self-administer
- ✓ Appropriate age, maturity and/or developmental level
- ✓ Ability to use correct technique in administering the medication
- ✓ Willingness to comply with school/program rules about the use of the medication while in the setting

Parent/Guardian Factors:

- ✓ Desire for student to self-carry and self-administer
- ✓ Awareness of program policies and parent responsibilities
- ✓ Commitment to ensuring that the child has the medication, medications are refilled when needed, medications are not expired.
- ✓ Provision of back-up medication for emergencies.

School/Program Factors:

- ✓ Availability of trained staff while children are in the program setting
- ✓ Availability of trained staff in case of loss or inability to administer medication
- ✓ Ability to disseminate information about medication use to all staff who need to know
- ✓ Communication system to contact appropriate staff in case of a medical emergency
- ✓ Opportunity for school nurse to assess child's status and technique
- ✓ Availability of the school nurse to provide oversight and support

If you have any questions regarding medication administration while at camp, feel free to contact Patty McCall, RN, Ajax Adventure's Nurse Consultant at 970-920-5373.

## 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**

_____ _____
**Phone Number** **Date**

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

Kids First
CHILDCARE RESOURCE CENTER

# CONTRACT TO CARRY/SELF-ADMINISTER MEDICATION

*This Contract is for students diagnosed with asthma, anaphylaxis, severe allergies, and/or other related life-threatening conditions and is in effect for the current school year unless revoked by a physician or if the Student fails to meet contingencies cited below.*

Student's Name: _____Date: _____

Program: _____DOB: _____

Medication: _____Purpose of Medication: _____

## Student

• I agree to keep my Medication with me at school and use it in a responsible manner as instructed by my above referenced health care provider.
• I will notify the school office staff if my condition for which I'm prescribed the Medication presents any unusual difficulty.
• I will notify the program staff if and when I use the Medication.
• I will not allow any other student to use my Medication.

•Student Signature: _____

## Parent

• I will assure that my child, the above referenced student, will carry his/her Medication as prescribed, and that the device containing the Medication to the above referenced school is appropriately labeled by a pharmacist or healthcare provider and contains Medication that has not expired.
•I will assure that back-up Medication is provided to the health office staff at the above-referenced program for emergencies.
• I will review the attached healthcare plan on a regular basis with my child.

•Parent Signature: _____

## Nurse Consultant

- I will assure that the Student can demonstrate the correct technique for self-administering the Medication.
- I agree to assure that appropriate school staff is made aware of the Student's condition and the need for the Student to carry the Medication
- I agree to assign designee to make a 911 emergency call if and when the Student is exposed in such a way as to require his/her use of epinephrine (Epi-pen).

- RN Signature: _____

# Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

Student's Name: _____D.O.B. _____ Grade: _____
School: _____ Teacher: _____
**ALLERGY TO:** _____
_____
History: _____
_____
Asthma: ☐YES (Higher risk for severe reaction) ☐NO

To be completed by healthcare provider

## ◊ 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: _____

**Student Name:** _____ **DOB:** _____

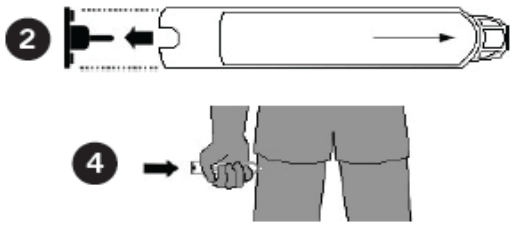
**TRAINED/DELEGATED STAFF MEMBERS**

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

Self-carry contract on file. ◯Yes ◯No Medication located in: _____

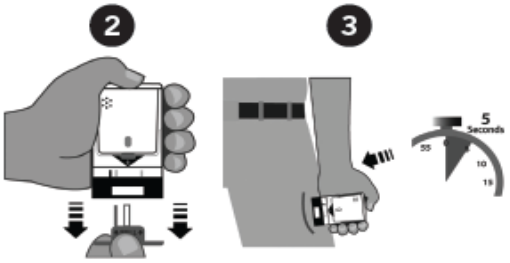
## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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:

**COLORADO STATE ASTHMA CARE PLAN**

Photo of child

| | |
|---|---|
| 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:

**GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE** (Health provider initial all that apply)

☐Give 2 puffs of rescue inhaler 15 minutes before activity. Indications: ☐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 rescue inhaler)

| IF YOU SEE THIS: | DO THIS: |
|---|---|
| ▪ Difficulty breathing<br>▪ Wheezing<br>▪ Frequent cough<br>▪ Complains of chest tightness<br>▪ Unable to tolerate regular activities but still talking in complete sentences<br>▪ Other: | ▪ Stop physical activity<br>▪ Give rescue inhaler *(name)*:<br>☐ 1 puff ☐ 2 puffs ☐other: ☐ Via spacer<br>▪ If no improvement in 10-15 minutes, repeat use of rescue inhaler:<br>☐ 1 puff ☐ 2 puffs ☐other: ☐ Via spacer<br>▪ If student's symptoms do not improve or worsen, call 911<br>▪ Stay with student and maintain sitting position<br>▪ Call parents/guardians and school nurse<br>▪ 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 within 20 minutes, 911 will be called

**RED ZONE: EMERGENCY SITUATION** (Health provider complete dosing for rescue inhaler)

| IF YOU SEE THIS: | DO THIS IMMEDIATELY: |
|---|---|
| ▪ Coughs constantly<br>▪ Struggles or gasps for breath<br>▪ Trouble talking (only able to speak 3-5 words)<br>▪ Skin of chest and/or neck pull in with breathing<br>▪ Lips or fingernails are gray or blue<br>▪ ↓ Level of consciousness | ▪ Give rescue inhaler *(name)* :<br>☐ 1 puff ☐2 puffs ☐ Other: ☐Via spacer<br>▪ Repeat rescue inhaler if student not improving in 10-15 minutes<br>☐ 1 puff ☐ 2 puffs ☐ Other: ☐Via spacer<br>▪ Call 911 Inform attendant the reason for the call is asthma<br>▪ Call parents/guardians and school nurse<br>▪ Encourage student to take slower deeper breaths<br>▪ Stay with student and remain calm<br>▪ *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 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

_____ _____ ☐504 Plan or IEP

School Nurse Signature DATE

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

EPILEPSY FOUNDATION®
Not another moment lost to seizures™

# 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:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

## SEIZURE INFORMATION:

| *Seizure Type* | *Length* | *Frequency* | *Description* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs:_____

Student's reaction to 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

**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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

## EMERGENCY RESPONSE:

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

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

☐ Contact school nurse at _____

☐ Call 911 for transport to _____

☐ Notify parent or emergency contact

☐ Notify doctor

☐ Administer emergency medications as indicated below

☐ Other_____

## TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

| Daily Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|
| | | |
| | | |

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES◯ NO◯

If YES, Describe magnet use_____

## SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

**Physician Signature:**_____ **Date:**_____

**Parent Signature:**_____ **Date:**_____