Permission for Medication Administration at School and Child Care

The parent/guardian of _____ ask that school/child care staff give the
Child's Name

following medication _____ at _____
Name of Medicine & 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, route, 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 school/child care 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. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

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 school staff delegated to administer medication.

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

_____ _____
Work Phone Alternate Phone

****

Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported:		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____/_____
Print Name of Health Care Provider Phone & Fax Number

_____ _____
Signature of Child Care Health Consultant or School Nurse Date

Log 2 Week Medication Administration

School/Child Care:			
Child's Name:	Birthdate:		Classroom:
Medication:	Dosage:	Route:	Time to be given:
Start Date:	End Date:		Expiration Date:
Special Instructions:			
Health Care Provider Prescribing Medication:			Phone:
Parent Name:	Parent Work Phone:		Parent Cell Phone:

Time	Week of:					Week of:				
	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:
AM:										
AM:										
PM:										
PM:										

Include time medication given and initials. If child absent, mark box with "A"; If medication not given, mark box "NG". Document reason not given in comments.

Date & Comments:

Staff Signatures	Initials

Intake and Count for All Medication

All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e. Ritalin, Dexedrine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials

Log – Daily - Controlled Medications Administered

Use one sheet for each child and each medication

School/Child Care Program:		
Child's Name:	Birth Date:	Classroom:
Medication:	Dosage:	Route
Time medication to be given:		
Length of time medication is to be given:	Start Date:	End Date:
Special Instructions:		
Name of Health Care Provider Prescribing Medication:		Phone:

All medication received must be counted and signed by staff member as well as guardian

Date	# of Pills Received Date & Initial (Staff & Guardian)	Time of Administration	# of Pills Remaining	Initials	Comments

Parent / Staff Signatures	Initials	Date

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

PARENT/GUARDIAN COMPLETE AND SIGN:

School/grade: _____

Child Name: _____ Birthdate: _____

Parent/Guardian Name: _____ 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 Department of Education

Revised: March 2018

Allergy & Anaphylaxis Action Plan

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

Place child's Photo here

To be completed by healthcare provider

ALLERGY TO: _____
History: _____
Asthma: YES NO *Higher risk for severe reaction

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

◊ STEP 1: TREATMENT

ǂ Potentially life threatening: give epinephrine first, and then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly (check one): **Call 911 if given**
Epipen 0.3 mg or Auvi Q 0.3mg / EpiPen®Jr. 0.15 mg or AuviQ 0.15mg or Mylan Brand Generic Epinephrine
Administer 2nd dose if symptoms do not improve in 15 – 20 minutes or sooner if noted_____

Antihistamine:
give_____
(Medication/dose/route)

(IF **ANTIHISTAMINE HAS BEEN GIVEN, PARENT MUST BE NOTIFIED AND STUDENT PICKED UP FROM PROGRAM)**

Asthma Rescue (if asthmatic): give_____
(Medication/dose/route)
(Remember the student needs a Colorado Asthma plan as well if has Asthma and will need inhaler other than Allergic Reaction)

Provider (print) _____ Phone Number: _____
Provider's Signature: _____ Fax Number_____
Start Date: _____ End Date: _____ (End date can not be more than one year!)

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. **This Health Care Plan will be effective for one school year.**

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Additional comments and guidelines

1.
2.
3.
4.

◊ 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) _____

Emergency Medication located in: _____

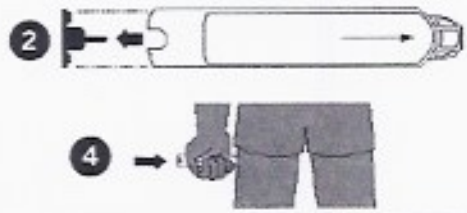
_____ Epinephrine pen expires: _____

_____ Antihistamine expires: _____

_____ Inhaler expires: _____

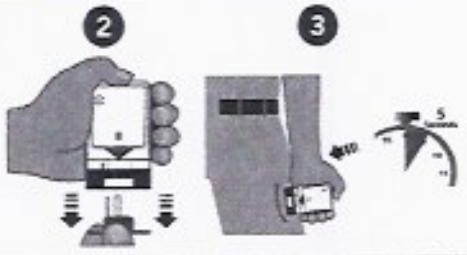
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



1-800-222-1222 poison control

Incident Report Medication Administration

This form is to be completed whenever any one of the "Rights" of Medication Administration is not in place.

Child's Name:	Birthdate:	School/Child Care:	Classroom:
Name of Medication:	Dose:	Time to be given:	Route:
Date and Time Incident Discovered:			
Person Completing this Form:			

Please describe the INCIDENT below. Always inform the Child Care Health Consultant or School Nurse of this situation. If the student was injured during this incident, further documentation and reporting will be required.

	Describe the Exceptional Situation	**Describe Action/Follow-Up Taken**
Right Student		
Right Medication		
Right Dose		
Right Route		
Right Time		
Right Documentation		
Right written orders signed and dated by parent and doctor		
Communication:		☐ Parent Notified: Date/Time: _____ ☐ Nurse Notified: Date/Time: _____ ☐ Principal/Director Notified: Date/Time: _____ ☐ if needed, 911 or Poison Control Notified: Date/Time: _____

Nurses Comments/Corrective Action Taken:

CCHC/SN: _____ Date: _____

Pediatric Nurse Consulting Services, LLC

Marlene A Evans BSN, RN
1005 W. 4th Ave
Broomfield, Colo 80020

Cell: 303.906.8399
Fax: 303.484.7972
m.evansrn@gmail.com

REFUSAL TO PROVIDE MEDICATION FORM

SCHOOL/DAYCARE/CAMP PROGRAM SITE: _____

From: _____
(parent/guardian name)

Regarding: _____ Date of Birth: _____
(child's name)

When I enrolled my child at your school/site, I informed you that my child has the following medical condition _____. However, at this time I do not wish to supply you with any medication for the above-mentioned condition and I take full responsibility for any reactions or problems related to my child's condition while he/she is in your care. I acknowledge that I have been informed that if any emergency situation occurs, 911 will be called to provide care for my child. I also understand that if 911 is called, I am financially responsible for any bills incurred.

I have reviewed this with my child's medical care provider and their signature is below to concur with my decision in regards to my child's medical condition.

***Parent/Guardian Signature:	Date:
Parent/Guardian Printed Name:	
***Signature of Health Care Provider:	License Number:
Health Care Provider Printed Name:	
Phone Number:	Date:

Pediatric Nurse Consulting Services, LLC

Marlene A Evans BSN, RN
1005 W. 4th Ave
Broomfield, Colo 80020

Cell: 303.906.8399
Fax: 303.484.7972
m.evansrn@gmail.com

Medications on Site

Date_____

Child Name	Location of Med	Exp/Med	Exp/Paperwork

SOON TO BE EXPIRED MEDICATION FORM

PROGRAM SITE: _____

Date: _____

To the Parents of: _____
(child's name)

RE: Expiration(s) of medication(s) and/or Medication Administration Paperwork.

In reviewing your child's paperwork and medication(s), it was noted that they have some items expiring. We have listed the items below. We wanted to let you know that in advance so that you can provide us with current paperwork and/or medications so that there will not be any interruption in our ability to administer the meds to your child.

We appreciate your assistance in this matter so that we can provide medication administration services to your child safely and in accordance with regulations.

ITEM	EXPIRATION DATE

Sincerely,

_____
: Program Site Director)

☐ Parent/Guardian Copy ☐ BASE Copy ☐ School/Nurse Consultant Copy ☐ Student File Copy

DISPOSAL OF MEDICATIONS*

SCHOOL/CHILD CARE PROGRAM: _____

Date	Medication/dose	Amount	Signature/Witness	Comments

*This form may be edited.