To Parents and Guardians:

Here in the health office we just wanted to take a few moments to clarify reasons you should keep your child at home. Our goal is always to "promote and maintain the physical, mental, and social health of children so they can receive the maximum benefit from educational opportunities," (Colorado Department of Public Health and Environment) - but we need your help!

Our guidelines are based on the desire that your child recover as quickly as possible, without exposing other students to an illness and per recommendations set forth by Colorado Department of Public Health and Environment. In general, if you are unsure whether or not to send your child to school, you should probably keep them home for one day.

We strongly encourage you to keep your contact information up to date and it is also helpful to provide the health office staff with an additional contact person if you are unable to be reached. Please remember, for the safety and well being of your child, it is imperative you pick your child up AS SOON AS POSSIBLE when contacted.

As always, you are welcome to contact your school's health office with any questions or concerns.

Here are some guidelines you can follow:

Rashes: Your child should be kept at home unless a note provided by their doctor states the rash is not contagious or until the rash resolves on its own

Vomiting and Diarrhea: Your child should be kept at home until vomiting and diarrhea has stopped for 24 hours *A child will be sent home if they have vomited at school

Fever of 100 degrees or more: Keep your child at home until they have been fever free for 24 hours without the use of medication (i.e. Tylenol or Ibuprofen) *A child will be sent home for a fever greater than or equal to 100 degrees

Common cold: Keep your child at home if they do not feel comfortable enough to participate in usual activities, require more care than school personnel are able to provide, have a lot of nasal discharge, or a persistent cough or wheezing

Strep throat: Your child may return to school after 24 hours of antibiotic treatment and when symptom free

Pink eye (conjunctivitis): Your child should be kept at home and treated until your physician advises their return (usually after 24 hrs of antibiotic treatment)

Impetigo: Your child should be kept at home and treated until your physician advises their return (usually after 24 hours of antibiotic treatment and site is not draining or oozing and can be covered)

Chicken pox: Your child should remain home for approximately one week after symptoms appear or until all papules (water-filled lesions) are scabbed or crusted over

Persistent cough: Your child should remain at home if the cough is persistent enough to disrupt class

Ear infections or drainage from an eye or wound: Your child should remain at home until your physician advises their return

Reference: Colorado Department of Public Health and Environment- Infectious Disease in School Settings: Guidelines for School Nurses and Personnel

Diann Hilliard

Please don't hesitate to call me with any questions or concerns at:

720-972-3625 or e-mail diann.m.hilliard@adams12.org

Adams 12 Five Star Schools

PARENT/LEGAL GUARDIAN'S RELEASE FOR ADMINISTRATION OF MEDICATION OR PROCEDURE AT SCHOOL
AND
AUTHORIZED PRESCRIBER SIGNED ORDER

Health Services

The undersigned **parent/legal guardian** of _____, Date of Birth_____,
(Student's Name)
hereby requests Personnel employed by Adams 12 Five Star Schools to administer or supervise administration of medication or a procedure as ordered by an authorized prescriber. **This is effective for the current school year.**

It is required by Adams 12 Five Star Schools, as a condition to its agreement to administer any medication, that the medication be prescribed by a licensed physician either MD or DO, dentist, or other authorized prescriber and that it will be furnished by the parent/guardian of the student in a container dispensed by a pharmacy or in an original over-the-counter container which is labeled with the student's name, medication name, dosage, and time when the medication is to be given. It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. By signing this release I hereby authorize employed personnel of Adams 12 Five Star Schools to contact the authorized prescriber, if necessary, to clarify any written order. Adams 12 Five Star Schools policy requires that non-emergency medication, both prescription and over-the counter, be kept in a locked area of the school Health Office. The medication will be administered by Adams 12 Five Star Schools personnel according to the authorized prescriber's written order/treatment plan, parent permission, and as specified in Superintendent Policy 5420.

School: _____ Phone: _____ Fax: _____

PARENT Signature: _____ Date: _____

AUTHORIZED PRESCRIBER'S SIGNED ORDER FOR MEDICATION or PROCEDURE ADMINISTERED AT SCHOOL

Medication Name: _____

Medication Dosage:

1. _____ MG Tablets/Chewable/Capsules/Liquids/Ampules

OR

2. Inhalers - Puffs to be given: _____ puffs

Route:

☐ Oral ☐ Topical ☐ Rectal ☐ Inhaled ☐ Nebulizer ☐ G-tube

Procedure: ☐ G-Tube Feeding ☐ Catheterization ☐ Pulse Oximetry

Other: _____

Time to be given: _____

Prior to exercise: ☐ Yes ☐ No

May be repeated every _____

Special instructions: _____

_____

Start Date: _____

Stop Date: _____

Purpose:

Possible Side Effects:

Other Comments:

PRINTED NAME of Authorized Prescriber: _____

Authorized Prescriber Signature: _____ Date: _____

Office Address: _____ City: _____ Zip: _____

Office Phone: _____ Office Fax: _____

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.	
Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

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

☐ **Life threatening allergy** : Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- 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

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.

☐ 504 PLAN OR IEP

PARENT SIGNATURE _____ DATE _____ SCHOOL NURSE SIGNATURE _____ DATE _____

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: _____ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	**DO THIS:**
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: 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 with approval from school nurse.

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE _____

Copies of plan provided to: Teacher(s) ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

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

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT

☐ **Give epinephrine immediately if the allergen was definitely ingested, even if no symptoms**

SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy,
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting, severe diarrhea
- OTHER: Feeling something bad is about to happen, confusion

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

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

→

1. Alert parent/guardian and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. 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 in _____ minutes, or if 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: _____

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: _____