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:_____

_____

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

Place child's photo here

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:

LUNG: Short of breath, wheeze, repetitive cough
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Swelling of the tongue and/or lips
HEART: Pale, blue, faint, weak pulse, dizzy
SKIN: Many hives over body, widespread redness
GUT: Vomiting or diarrhea (if severe or combined with other symptoms
OTHER: Feeling something bad is about to happen, Confusion, agitation

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

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

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and 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 ____ minutes or more, or 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: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic 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) _____

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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

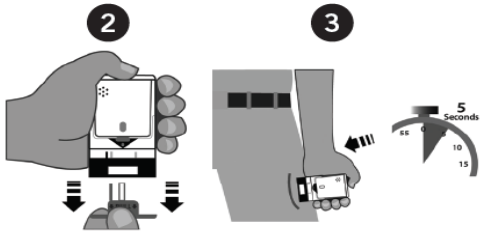
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

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

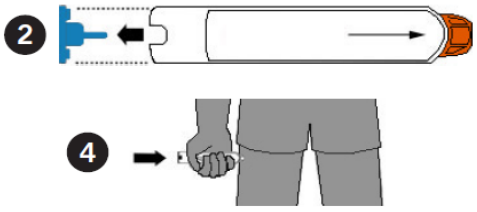


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it ‘clicks’.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

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

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and 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 health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), 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.

Parent/Guardian Signature _____ **Date** _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other**: _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ 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 **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

IF YOU SEE THIS:		DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely 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 or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
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/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature _____ **Print Provider Name** _____ **Date** _____

Good for 12 months unless specified otherwise in district policy.

Fax _____ **Phone** _____ **Email** _____

School Nurse/CCHC Signature _____ **Date** _____

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021

Immunization

Certificate of Medical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak. Medical exemptions need to be filed only once unless the student's information or school changes.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: ☐ Female ☐ Male ☐ X	

Parent/Guardian Completing This Form: ☐ Check if an emancipated student or student over 18 yearsold

Last Name:	First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		☐ Check if Not Applicable
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry

Check each vaccine declined:		List medical contraindication(s) for each vaccine declined:
☐	Hepatitis B	
☐	Diphtheria, tetanus, pertussis (DTaP, Tdap)	
☐	Haemophilus influenzae type b (Hib)	
☐	Inactivated poliovirus (IPV)	
☐	Pneumococcal conjugate (PCV13)	
☐	Measles, mumps, rubella (MMR)	
☐	Varicella (chickenpox)	

Statement of Exemption

The physical condition of the above named student is such that vaccination would endanger their life or health or is medically contraindicated due to other medical conditions. The information I have provided on this form is complete and accurate.

REQUIRED Signature:_____ Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or Physician Assistant (authorized pursuant to section 12-240-107 (6), C.R.S.)

REQUIRED: _____ Professional License Number:_____

(State/Territory)

Under Colorado law, you have the option to exclude your child's/your information from the Colorado Immunization Information System (CIIS). To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Immunization
Certificate of Nonmedical Exemption

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases, as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. "Nonmedical exemption" means an immunization exemption based upon a religious belief whose teachings are opposed to immunizations or a personal belief that is opposed to immunizations. Prior to kindergarten, a nonmedical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.[1,2] From kindergarten through 12th grade, a nonmedical exemption must be filed every year during the student's school enrollment/ registration process.[1] Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below and obtain all required signatures; incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth:	Sex: ☐ Female ☐ Male ☐ X	

Parent/Guardian Completing This Form: ☐Check if an emancipated student or student over 18 years old

Last Name:	First Name:	Middle Name:
Relationship to student: ☐ Mother ☐ Father ☐ Legal Guardian		

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		☐Check if Not Applicable
Address:		
City:	State:	Zip Code:

Required Vaccines for School Entry - Place an "X" next to each vaccine for which you are claiming a nonmedical exemption.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV13)
	Hepatitis B		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student themself (emancipated or over 18 years of age) and am claiming a nonmedical exemption from the vaccine(s) indicated above. The information I have provided on this form is complete and accurate. I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, www.spreadthevaxfacts.com/, www.ImmunizeForGood.com/ for additional information on the benefits and risks of vaccines and the diseases they prevent. I can contact the Colorado Immunization Information System (CIIS) at www.covaxrecords.org or my health care provider to locate my child's/my immunization record.[3]

REQUIRED Signature: _____ Date: _____
Parent/Legal Guardian/Student (emancipated or over 18 years old)

REQUIRED Provider Signature Section:

REQUIRED Print Name, Title, and Signature:_____ Date:_____
Physician (MD, DO), Advanced Practice Nurse (APN), Physician Assistant, Registered Nurse (RN) or Pharmacist (authorized pursuant to section 12-240-107 (6), C.R.S.)
REQUIRED Colorado Professional License Number:_____

[1] Colorado Board of Health rule 6 CCR 1009-2: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7698&fileName=6%20CCR%201009-2

[2] 2021 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a nonmedical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt- out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

STUDENT HEALTH INFORMATION
School Year : _____

STUDENT NAME:_____Birthdate:_____Grade:____School:_____

HEALTH CONCERNS	YES	NO	MEDICATION (Name, dosage)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DESCRIBE
ASTHMA/ RESPIRATORY					
SEVERE ALLERGIES				FOOD LATEX INSECTS NUTS	type of reaction date of last reaction:
DIABETES				Equipment:	
HEAD INJURY					
SEIZURES/ NEUROLOGICAL/ MIGRAINES					Type & date of last episode
HEART/BLOOD					
MUSCLES/BONES/ JOINTS/SKIN					
BLADDER/KIDNEY					
STOMACH/ INTESTINES/BOWELS					
IMMUNE PROBLEMS					
OTHER HEALTH CONCERNS					
HEARING CONCERNS				Hearing aides? Preferential seating?	
VISION CONCERNS				Glasses or contacts? Reading only?	
GROWTH & NUTRITIONAL CONCERNS					
DEVELOPMENTAL CONCERNS					
EMOTIONAL/ BEHAVIORIAL					

- Routine or daily medications, treatments or therapies (not listed above):
- Activity restrictions in school?
- Special medical equipment required in school? (eg. oxygen, wheelchair)
- Have there been any significant changes in your child's health over the last year? Explain:
- ILLNESSES, HOSPITALIZATIONS, ACCIDENTS/ INJURIES and dates: (use other side if necessary)

Health Care Provider(s) & Phone #:

PARENT/GUARDIAN SIGNATURE_____ HOME/WORK PHONE #_____DATE completed:_____

Name of school nurse: _____ your school nurse can be reached at: _____
Please contact the school nurse directly if you would like to discuss any of the above information that you feel is confidential.

Medication Administration Permission for 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 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. All medication(s) that are 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 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

Child's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____ Route _____

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

Purpose of medication: _____ Side effects to be reported: _____

Starting Date: _____ Ending Date: _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

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

_____ _____
School Nurse or Child Care Health Consultant signature Date