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!

RESPIRATORY HEALTH CARE PLAN

Infants through preschool age

Child's Name_ _____ **DOB**__ _____

School/Center_ _____

Triggers: (check those which apply to this child)

☐Weather changes ☐Colds ☐Cold air ☐Exercise

☐Pollens (trees, weeds) ☐Molds ☐Animal dander- Type_____

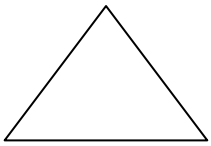
☐Dust and dust mites ☐Strong odors ☐Other:_____

List all routine daily meds (Name, Dose, Time)*: include all meds taken at home

Health Care Provider circle:
Baseline breaths per minute(circle)

18-30 **20-40**

Staff will be trained in taking accurate respiratory rate by nurse.



Yellow Zone
Warning

Steps to Take During an Asthma Episode:

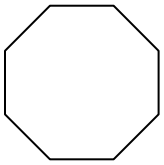
1. Count breaths per minute.
2. Observe for:
   - -Frequent cough, runny nose, stuffy nose.
   - -Increased cough with rapid breathing.
   - -Some decrease in play and/or appetite.
   - -Occasional wheeze you can hear.
   - -Other: _____

Health Care Provider circle/fill in:
Greater than

30 **40** _____**breaths/min**

Treatment @ child care:

1. Give medicine: _____ Dose: _____ Time: _____ End Date: _____
   Special instructions: _____
2. Encourage child to sit up right, relax and take deep even breaths.
3. Give sips of warm water.
4. Notify guardian if: _____
5. Stay with child and recheck breaths per minute 15 minutes after treatment.
6. If no improvement with medication, call parents to pick up child for further evaluation.
7. Notify nurse consultant and document.



RED ZONE
DANGER

Seek Emergency care if :

- -Continuous coughing, wheezing,
- -Shallow rapid breathing
- -Pale or blueness of fingernails and/or lips
- -Loss of consciousness
- -Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone
- -For infants: extremely fussy and /or difficulty sucking or eating.

Health Care Provider circle/fill in:
Greater than:

50 **60** _____**breaths/min**

Treatment @ child care/school:

1. **Call 911**
2. Call Parent and nurse consultant.
3. Other: _____

Health Care Provider's Signature_____Start date_____End date_____

Please attach completed medication authorization: _____yes _____ not needed.

RESPIRATORY HEALTH CARE PLAN (Page 2)

Child's Name: _____ **School/Center**: _____

Emergency Contact Information

Guardians' names: _____
Guardians' daytime phone numbers: _____
Guardians' address: _____

Alternative person if unable to contact guardians: _____
Alternative persons' relationship to the child: _____
Alternative persons' phone number(s): _____

Health care provider who should be called regarding emergency care due to a severe asthma episode:
Name: _____
Phone: _____
Fax: _____

Hospital Preference: _____

Field Trips: Medication must accompany student on all field trips. (spacer if at school/center)
A copy of this health care plan and current phone numbers must be with a staff member.
Teacher must be instructed on the correct use of the medication.

Parent's signature indicates permission to contact child's health care provider(s) listed above as needed. I understand that the School Nurse Consultant may delegate this care plan to unlicensed school personnel. I also understand this plan may be shared with school personnel if it is determined that the information may impact the student's educational experience and/or safety.

Health Care Providers signature: _____ Date: _____

Parent signature: _____ Date: _____

Nurse's signature: _____ Date: _____

Administrator's signature: _____ Date: _____