Medication Administration Instructional Program
Sample Forms
Table of Contents

These forms are provided as a resource to the RN instructor for use during the Medications Administration Training. Forms may be copied. Please note: the format of these forms may be modified to fit the needs of schools, child care programs and camps as long as the information included on the forms meets the basic requirements outlined in the Instructor Manual.

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SAMPLE FORMS
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Washing Your Hands

1. Turn water on.

- Be sure **clean, disposable paper towels** are available.
- Turn on **warm water.** (90-110°F in NC)

2. Wet hands.

- Wet hands with water.

3. Apply soap.

- Apply **liquid soap.**

4. Wash hands.

- Wash hands well for at least 10-15 seconds. Rub top and inside of hands, under nails and between fingers.

5. Rinse hands.

- Rinse hands under running water for at least 10 seconds.

6. Dry hands.

- Dry hands with clean, disposable paper towel.

7. Turn water off.

- Turn off the water using the paper towel.

8. Throw paper towel away.

- Throw the paper towel into a lined trash container.

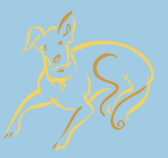
Teach children to wash their hands:

- Upon arrival to the center

- Before and after eating

- After using the toilet/diapering

- After coughing or contact with body fluids: runny nose, blood, vomit
- Before and after using water tables
- After outside play
- After handling pets



- Whenever hands are visibly dirty
- Before going home

North Carolina Child Care Health & Safety Resources Center • 1.800.367.2229 • www.healthychildcarenc.org • The development, translation, and mailing of the Washing Your Hands Poster are supported by funding from the Child Care and Development Fund Block Grant of the Child Care Bureau, Administration on Children and Families, USDHHS, through a contract between the NC Division of Child Development, NCDHHS, and the Department of Maternal and Child Health, School of Public Health, The University of North Carolina at Chapel Hill.

HANDWASHING

Handwashing is the single most effective practice that prevents the spread of germs in the child care setting.

When should hands be washed?

Children:

- ☐ Upon arrival to the center
- ☐ Before and after eating
- ☐ After using the toilet/diapering
- ☐ Before using water tables
- ☐ After playing on the playground
- ☐ After handling pets
- ☐ After coughing or contact with runny noses
- ☐ Whenever hands are visibly dirty
- ☐ Before going home

Providers

- ☐ Upon arrival to work
- ☐ Before handling food or feeding children
- ☐ After using toilet/diaper changing
- ☐ After coughing, contact with runny noses, vomit, etc
- ☐ After handling pets or pet cages
- ☐ Whenever hands are visibly dirty
- ☐ Before and after administering first aid
- ☐ After cleaning up
- ☐ After removing gloves
- ☐ Before giving medication
- ☐ Before going home

How to wash hands

- ✓ Refer to the Handwashing handout
- ✓ Use liquid soap
- ✓ Wash well under running water for at least 10-15 seconds.
- ✓ Be sure to wash areas between fingers, around nail beds, under fingernails and back of hands
- ✓ Use hand lotion

Hand sanitizers may be used for staff and children 3 years of age and older, at times and in areas where handwashing facilities are not available

Infants and Toddlers

Use soap and water at a sink if you can. If a baby is too heavy to hold for handwashing at the sink then:

- ☐ Wipe the child's hands with a damp paper towel moistened with a drop of liquid soap.
- ☐ Wipe the child's hands with a paper towel wet with clear water
- ☐ Dry the child's hands with a paper towel
- ☐ Do not use hand sanitizers for young children under 3 years of age

Sample Policy

Administration of Routine Medications in the School, Child Care or Camp Setting

Purpose

To ensure safe and accurate administration of routine medications to all children in school, child care or camp settings. The RN consultant or staff Registered Nurse will delegate and supervise the task of medication administration only to those care providers and staff members who have completed the approved Medication Administration Training.

Because the administration of medication requires extra staff time and safety considerations, parents should check with their health care provider to see if a dosage schedule can be arranged that does not involve the hours the child is in school or child care setting.

Medication Administration Policy:

The following requirements must be met before administering medications.

- *Written Authorization from the Health Care Provider*
- *Parent Written Authorization*
- Medication in the original labeled container
- Proper care and storage of medication
- Documentation of medication administration

Nebulized medications and emergency injections (Epi-Pen®) require a written health care plan or instructions completed by the RN consultant and/or the child's health care provider.

Parents are responsible for providing all medications and supplies to the school/child care program. In most situations, children should not transport medications to and from school/childcare; this includes medication placed in a diaper bag or backpack. Special arrangements must be considered regarding the safe transport of medications for children attending camp programs.

Program staff may not deviate from the written authorization from the Health Care Provider with prescriptive authority. Program staff must count and record the quantity of controlled substances (e.g., Ritalin®) received from the parent, in the presence of the parent.

Medications that have expired or are no longer being used at the center should be returned to the parent or guardian. If the medicine has not been picked up within one week of the date of the request, then medication must be disposed of by a medication trained person or the RN, according to established procedures.

Medication Administration Procedure

Care and Storage:

Medications administered in school or child care settings should be stored in a secure, locked, clean container and under conditions as directed by the health care provider or pharmacist. Medications that require refrigeration should be stored in a leak-proof container (locked box) in a designated area of the refrigerator separated from food *OR* in a separate and locked refrigerator used only for medication.

Once all requirements are met, the care provider will administer the medications utilizing the

5 Rights of Medication Administration

1. Right Child
2. Right Medication
3. Right Dose
4. Right Time
5. Right Route

Documentation

Any medications routinely administered must be documented on the *Medication Log* by the person administering the medication. Refer to the "*Medication Log"* sample.

Medication Incidents

A medication incident is any situation that involves any of the following:

- Forgetting to give a dose of medication
- Giving more than one dose of the medication
- Giving the medication at the wrong time
- Giving the wrong dose
- Giving the wrong medication
- Giving the wrong medication to the wrong child
- Giving the medication by the wrong route
- Forgetting to document the medication

Medication incidents are documented on a *Medication Incident Report* and reported to the RN nurse consultant, child's parents, program administrator and health care provider (as appropriate). Medication incidents that involve medication given to the wrong child or an overdose of medication require consult with Poison Control.

DO NOT INDUCE VOMITING UNLESS INSTRUCTED BY POISON CONTROL.
POISON CONTROL NUMBER IS: 1-800-222-1222

Disposal of Medications

Medications that have not been picked up by the parent, once notified by program staff, must be disposed of by:

- Take unused, unneeded, or expired prescription drugs out of their original containers
- Mix the prescription drugs with an undesirable substance, like used coffee grounds or kitty litter, and put them in impermeable, non-descript containers, such as empty cans or sealable bags, further ensuring that the drugs are not diverted or accidentally ingested by children or pets
- Wrap these containers so that the content can not be easily seen
- Throw these containers in the trash
- It is the responsibility of the RN consultant or designated staff person to dispose of medications with one witness present.
- Document on the *Medication Log* or *Disposal Log* the, date, time, child's name, name of the medicine(s), signature of staff person or RN and witness.

DISPOSAL OF MEDICATIONS **SCHOOL/CENTER** _____

DATE	CHILD'S NAME	MEDICATION	AMOUNT	SIGNATURE/WITNESS

Self-Carry Medications
Students Carrying and Taking Their Own Medication in the School Setting

In Colorado, children may be allowed to self carry asthma and anaphylaxis medications in school as well as some group care settings. Self administration in these settings refers to situation in which students carry their medication on their person and administer the medication to themselves while in these settings as ordered by their healthcare provider, authorized by the parent and the school district or program policy. Typically this medication is not handled by school or child care personnel nor stored in the program's medication storage area.

According to Colorado Schoolchildren's Asthma and Anaphylaxis Health Management Act Guidelines a variety of "factors should be assessed *by the school nurse* in determining when a student should self carry and self-administer life-saving medications." These factors include, but are not limited to:

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

Open communication is the key and this communication should include healthcare providers, families, and school personnel especially the school nurse. In addition, a contract with all students who self carry is recommended so that the proper safeguards can be in place.

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!

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name:_____ **Birthdate:** _____

Allergies: ❑ None or Describe_____

Type of Reaction _____

Diet: ❑ **Breast Fed** ❑ **Formula** _____ ❑**Age Appropriate**

❑**Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ DATE: _____

Parent/Guardian Signature_____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities)_____

Allergies: ❑ None or Describe_____ Type of Reaction _____

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ❑ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level ❑Not at risk or Level _____**

****TB ❑Not at risk or Test Results** ❑ Normal ❑ Abnormal

****Screenings Performed: ❑Vision:** ❑Normal ❑Abnormal **❑Hearing:** ❑Normal ❑Abnormal **❑Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up_____

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age_____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

Dear Parents/ Guardians:

Many parents and staff members have questions regarding the use of medications. The following is some information from local and national pediatric experts about the use of medication in young children.

People in the United States spend millions of dollars on the use of over-the-counter medications, (for fever, pain, colds, and coughs). Many of these medications are unnecessary, and in the case of young children (particularly under the age of 5 years) the effect of these medications often produces side effects, instead of providing relief to bothersome symptoms.

In January 2008, the American Academy of Pediatrics (AAP) supported a public health advisory put out by the US Food And Drug Administration. This advisory recommended that OTC cough and cold medications should not be used for infants and children under age 2 because of the risk of life threatening side effects.

It is recommended that parents discuss the use of OTC medications with their health care provider before giving any medications to their child. Parents should be especially careful in giving OTC medications to an infant. Giving a child more than one cold or cough medicine to treat different symptoms can be dangerous. Some of the same ingredients may be in each product. Also, many of these medicines contain acetaminophen. Read labels carefully.

Use of Nonprescription Medications for Common Symptoms:

- If your child is playing and sleeping normally, nonprescription medications are not needed.
- Medications should only be given for symptoms that cause significant discomfort, such as repeated coughing or difficulty with sleeping. Consult with your health care provider.
- Viral illnesses respond well to rest, fluids and comfort measures.

Use of Antibiotics:

- More than 90% of infections are due to viruses.
- Antibiotics have no effect on viruses.
- Antibiotics kill bacteria (such as strep throat). It is essential to complete the full treatment, even though your child may feel well.
- When antibiotics are necessary, they should be given at home when possible; this has been made easier now that once and twice daily dosages are available

If Your Child Requires Medication While at Child Care or School:

- All prescription and nonprescription medication given in child care or school settings require a written authorization from your health care provider, as well as parent written consent. This is a child care licensing requirement. The medication authorization forms are available from the center or school.

- 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. For children with chronic health conditions, this can be determined in collaboration with the consulting registered nurse.

Guidelines for Safe Use of Medication:

- Keep medication out of the reach of children. Keep childproof caps on the container.

- Children should understand **adults are in charge of medicines**.
  It should not be referred to as "candy"

- Give the correct dose. Measure the dose out exactly.
  Use a measuring spoon, medicine spoon or syringe. One teaspoon = 5ml (cc).
  Kitchen teaspoons & tablespoons are **not** accurate; they hold 2-7ml (cc) and should not be used.

- Give the medicine at the prescribed times. If you forget a dose, give it as soon as possible and give the next dose at the correct time interval following the late dose.

- Give medications that treat symptoms (such as: persistent cough) only if your child needs it and never to children under 2. Continuous use is usually not necessary. Talk with your health care provider.

- Young children pay attention to adults who take medication. Sometimes a 2-year-old will tell you they have a headache or stomachache, this is not a reason to use medication. Watch the symptoms and give your child attention in other ways.

- Fever reducing medication can be given for fever over 102°. Remember that fever can be the body's way to fight infection. Be careful not to casually use fever-reducing medication.

- Be especially careful with over-the-counter medications. Some adult strength medications are never used with children. Talk with your health care provider or pharmacist.

- Check the medication label and read the expiration dates. Expired medications can lose their strength and can be harmful.

What to do if Your Child Refuses to Take Their Medicine

- Some medications do not taste very good. Your child can suck on a popsicle beforehand to help numb the taste. Or you can offer your child's favorite drink to help wash it down.

- If the medication is not essential (such as most nonprescription medication) then discontinue it. If you are not sure, call your health care provider.

- If the medication is essential, be firm, help them take it and give a reason for the need.

Should your child need to take medication, either at home at school or at child care, be sure to talk with the program director. When your child is well enough to return to school/childcare, the staff may be able to assist you in monitoring your child during this time, be able to share information about your child's symptoms and how they may be responding to the medication and other comfort measures.

References:
Your Child's Health, 3rd edition, Dr. Barton Schmitt, Bantam Books, 2002.
Healthy Child Care America*: Controlling the Spread of Infectious Disease in Child Care Programs*, 2001
Managing Infectious Diseases in Child Care and Schools, Susan Aronson, Timothy Shope, AAP, 2005
http://www.aap.org/advocacy/releases/jan08coughandcold.htm

Handout developed by The Children's Hospital School Health Program 2001 revised 2005, 2008 (303) 281-2790

Medication Administration Log

Child's Name: _____ **Date of Birth:** _____ **Rm.:** _____

Medication: _____ **Time(s):** _____

Amount:: _____ **Route:** _____ **Start Date for Medication:** _____ **End Date:** _____

Special Instructions: _____

Name of Health Care Provider Prescribing Medication: _____ **Phone:** _____

Parent name: _____ **Parent Work #:** _____ **Parent Home #:** _____

	Week of: Mon Date	Tue Date	Wed Date	Thurs Date	Fri Date	**Week of:** Mon Date	Tue Date	Wed Date	Thu Date	Fri Date
A.M.										
P.M.										

Include Time Medication was Given and Initial

If the child is absent, mark box with an "A" ; If the medication was not given, mark box "NG" . Document reason medication was not given in Comments.

Date & Comments:

Staff Signatures	**Initials**

Pills Received: **(All controlled medications must be counted, e.g., Ritalin)**

Medication Administration Log

School/Childcare Program _____

Child's Name: _____ **Date of Birth:** _____

Medication*: _____ **Dosage:** _____ **Route:** _____

Start Date for Medication: _____ **End Date:** _____

Special Instructions: _____

Name of Health Care Provider Prescribing Medication: _____ **Phone:** _____

Parent name: _____ **Parent Work #:** _____ **Parent Home #:** _____

	Week of:					**Week of:**				
	Mon Date	**Tue Date**	**Wed Date**	**Thurs Date**	**Fri Date**	**Mon Date**	**Tue Date**	**Wed Date**	**Thu Date**	**Fri Date**
A. M.										
P. M.										

Include Time Medication was Given and Initial If the child is absent, mark box with an "A" ; If the medication was not given, mark box "NG" . Document reason medication was not given in Comments.

***All controlled medications must be documented on a Controlled Substance Log**

Date & Comments:

Staff Signatures	**Initials**

MEDICATIONS AT SCHOOL/CHILD CARE - USE ONE SHEET FOR EACH STUDENT AND A SEPARATE SHEET FOR EACH MEDICATION

Name ______________________________ Birth Date __________ School ______________________________ Grade ______

Medication ______________________ Prescribing Practitioner's Name & Phone # ______________________________

Parent Name & Phone Number ______________________________

	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri
Medication	**Week of:**					**Week of:**					**Week of:**					**Week of:**				
Dosage **Route**																				
Times																				
Medication	**Week of:**					**Week of :**					**Week of:**					**Week of:**				
Dosage **Route**																				
Times																				
Medication	**Week of:**					**Week of :**					**Week of:**					**Week of:**				
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Dosage **Route**																				
Times																				
Medication	**Week of:**					**Week of :**					**Week of:**					**Week of:**				
Dosage **Route**																				
Times																				

If student is absent or medication was not given, record such in appropriate box. The person assisting with the medication signs their initials and time medication given in the block under the corresponding day of the week.

Signature	Initials	Date	Signature	Initials	Date

Daily Log of Ritalin/Controlled Medications Administered

Use one Sheet for Each Child

School/Childcare Program_____

Child's Name _____Birth Date _____Classroom_____
Medication_____Dosage_____Route_____
Time of day medication is 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

Staff Signature	Initials	Date

MEDICATION INCIDENT REPORT

Date of Report: _____ School/Center: _____

Name of person completing this report: _____

Signature of person completing this report: _____

Child's Name: _____

Date of Birth: _____ Classroom/Grade: _____

Date incident occurred: _____ Time Noted: _____

Person Administering Medication: _____

Prescribing Health Care Provider: _____

Name of medication: _____

Dose: _____ Scheduled time: _____

Describe the incident and how it occurred: _____

_____

_____

_____

Action taken/intervention: _____

Nurse Consultant notified: Yes___ No___ Date _____ Time _____

Parent/Guardian notified: Yes___ No___ Date _____ Time _____

Name of the parent/guardian that was notified: _____

Other persons notified: _____

Follow-up and Outcome: _____

_____

Building administrator's signature: _____

Nurse consultant's signature: _____

Medication Incident Report

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

Student's Name: _____ Grade: _____ School: _____

Name of Medication/Dose_____Time:_____Route_____

Date and Time Incident Discovered: _____

Person Completing this Form: _____

Please describe the INCIDENT below. Always inform the school nurse or nurse consultant 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 written orders signed and dated by parent and doctor?		
Right procedure? Other: _____ _____ _____		__ Parent Notified - date _____ time _____ __ Nurse Notified - date _____ time _____ __ Principal or Director Notified -date _____ time_____ __ 911 or Poison Control

Nurses Comments/Corrective Action Taken:

Signature of School Nurse: _____ Date: _____

This form adapted from a form provided by Aurora Public Schools, Aurora, CO

MEDICATION ADMININISTRATION ONSITE CHECKLIST

SCHOOL/CENTER: _____

DATE: _____ REVIEWED BY: _____, RN

RATING	A	NA	NI
CARE & STORAGE			
✓ Medications properly locked up			
✓ Area is clean			
✓ Refrigerated medications in designated area (box)			
✓ Epi-Pen® is stored at room temperature			
✓ Medication expiration dates current			
✓ Medications in properly labeled containers			
✓ Organized system			
✓ Disposal of medications			
PAPERWORK			
✓ Health care provider signature			
✓ Parent signature on completed information			
✓ Copy to nurse			
✓ Health care plans (as needed)			
Medications being given only by designated/trained staff			
DOCUMENTATION			
✓ All documentation in ink			
✓ Signature to match all initials on medication log			
✓ Controlled drugs are counted when brought to school/ child care and recorded			
✓ Medications being given at correct time			
✓ As needed drugs are given at proper intervals			
Areas of concern:			
Follow up plan:			
Comments:			

*** A = Acceptable *NA = Not Acceptable *NI = Needs Improvement**

FIELD TRIP MEDICATION

Student's Name:_____ Age:_____

Teacher:_____ Grade:_____

Medication:_____

Dosage:_____ Route: _____

Time to be given:_____ Date: _____

Person Giving Medication:
(Signature)

Date and Time Medication **was given:**
(Date) (Time)

Please return this paper to the health room after the field trip. Be sure to document on the student medication log upon return to school. Thank you.

Adapted from Academy School District #20 Field Trip Medication Form.

PROCEDURE GUIDELINES FOR ROUTINE FIELD TRIP MEDICATIONS

School/ Center		RN Delegator	:

PROCEDURE GUIDELINE	RN Initials
1. Confirms field trip plans with nurse consultant or designee at least 5 days prior to field trip.	
2. Verifies children needing medications and time to receive medications for field trips	
3. Maintains medications in a secure area during field trip	
4. Documents administration of medication on Medication Log copy	
5. Returns medication, medication authorization, and log copies immediately after return to school.	
6. Describes medication incident reporting.	
7. Identifies process to contact RN	

I have been trained and am competent in the described procedures for field trip medications. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Name (Print)	Delegatee Signature	Date

Delegating RN Signature: _____ Initials _____

FIELD TRIP MEDICATION HANDOFF RECORD

Date: _____ Destination: _____ Class/Grade: _____

Teacher:_____ Departure time: _____ Return time: _____

Nurse consultant or designated medication trained staff

I identified the child(ren) needing medication during the field trip described above. I prepared a copy of the medication log and authorization document and paired it with each original medication container.

Name: _____ _____ _____ _____
Print Name Signature Date Time

Student	Medication	Dosage	Time to be given

Field Trip Staff/Teacher

I maintained the medications in a secure area at all times during the field trip. I documented medication administration on the copy of the medication log. I reported any incidents to the nurse consultant and completed appropriate documentation. I returned the medications to the nurse consultant or designated medication trained staff.

Name: _____ _____ _____ _____
Print Name Signature Date Time

MEDICATION ADMINISTRATION SKILLS CHECK LIST

☐ NEW - *TEST SCORE:* _____ ☐ RENEW

Staff Name _____ Date of training _____

RN Instructor _____ School _____

Criteria	RN Initial & Date	Staff Member Initial & Date	Comments
1. Written Authorization a. Parent permission b. Health care provider authorization c. Health Care Plan (when needed)			
2. Medication in pharmacy labeled bottle			
3. Follows proper medication storage			
4. Demonstration procedure: a. Wash hands b. Check written instructions with the label c. Prepare without touching medication d. Double check the label and medication e. Identify child f. Observe child g. Follow 5 rights h. Check if child has taken the medicine i. Document j. Triple check label and return medicine to locked storage area			
a. Oral (Pills and liquid)			
b. Inhaled			
c. Eye/ear			
d. Topical			
e. Epi-Pen®			
f. Nebulizer treatments			
g. Peak Flow Meter, as applicable			
5. Documentation: medication log			
6. Procedure for medication error			
7. Process to locate RN consultant (pager)			
8. Student/child confidentiality			
9. Onsite supervision			

Are you certified in: Standard (Universal) Precautions (BBP) yes no First Aid yes no CPR yes no

Staff Member Signature_____ Initials_____

The above named staff member has completed medication administration training and is competent to administer routine medications.

Delegating RN_____ Date of Delegation_____

Delegating RN Signature _____ Initials _____

Medication Administration Instructional Program

Severe Allergy Module

SAMPLE FORMS
Table of Contents

These forms are provided as a resource to the RN instructor for use during the Medication Administration training. Forms may be copied. Please note: the format of these forms may be modified to fit the needs of schools, child care programs and camps as long as the information included on the forms meets the basic requirements outlined in the Instructor Manual.

HEALTH CARE PLAN
SEVERE ALLERGY TO:_

Student Name: School:
Birthdate: _____

Emergency Treatment

If student experiences mild symptoms:
several hives, itchy skin, itchy red watery eyes or nasal symptoms
OR if an ingestion is suspected:

Treatment:

1. Send student to health office **ACCOMPANIED.**
2. **Give of by mouth.**
   (amount and dosage:) (antihistamine)
3. Contact the parent or emergency contact person.
4. **If exposed - Have child wash face, hands and exposed area.**
5. Stay with the student; keep student quiet, monitor symptoms, until parent arrives.
   Watch student for more serious symptoms listed below.

Special Instructions:

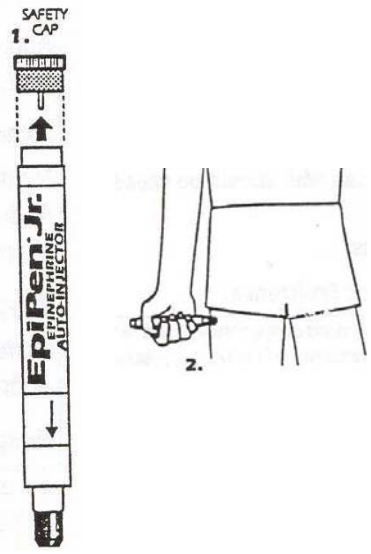
Symptoms that progress and can cause a life threatening reaction:

- *Hives spreading over the body.*
- *Wheezing, difficulty swallowing/ breathing, swelling (face, neck), tingling/swelling of tongue.*
- *Vomiting*
- *Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness.*

Treatment:

1. **Give:** ☐ **Epi-Pen Jr.®** (under 66lbs) **OR** ☐ **Epi-Pen®** (66lbs & over) **immediately**

   Place against upper outer thigh, through clothing if necessary.
2. **Call 911** (or local emergency response team) immediately.
3. Epi-pen® only lasts 20-30 minutes.
   ****Paramedics should always be called if Epi-Pen® is given****
4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.



Directions for use of Epi Pen®:

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi Pen® in impermeable can and dispose per school policy, or give to emergency care responder. (Do not return to holder)

It is understood by parents and health care provider(s) that this plan may be carried out by school personnel other than the School Nurse Consultant (RN). A RN is to be responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization (Required):_____ Date:_____

Parent/Guardian Signature (Required): _____ Date:_____

☐ Parent/Guardian Copy ☐Student Copy ☐School Copy ☐Transportation Copy

HEALTH CARE PLAN
SEVERE ALLERGY TO:_

Student Name: School:
Birthdate: _____

Allergies (food, insects, medication, etc):	**Reaction:**

Diet Restrictions:
For food allergies: ☐ parents will monitor school lunch menus or provide food and communicate with school personnel
☐ student will self monitor food choices
☐ teacher will assist child unable to self select food choices
☐ other

Medications used on a daily basis (include doses):
HOME:
SCHOOL:

REMINDER: School personnel must take Epi-Pen® or any other medication on all field trips.
Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature.
DO NOT FREEZE, refrigerate or keep in extreme heat.

Pertinent Health History (as completed by School Nurse):

EMERGENCY INFORMATION

Parent/Guardian	Number in order of preference		Number in order of preference	
Home Phone:				
Cell Phone:				
Work Phone:				
Pager Number:				
Home Address:				
Emergency Contact:	**Name:**	**Phone:**		
Emergency Contact:	**Name:**	**Phone:**		

Health Care Provider who should be called regarding the allergic reaction:

Name: _____
Phone: _____
Hospital Preference:

If _____ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required)_____ Date _____

School Nurse (RN) Signature: (Required)_____ Date _____

Administrator Signature: (Preferred)_____ Date _____

☐ Parent/Guardian Copy ☐Student Copy ☐School Copy ☐Transportation Copy

HEALTH CARE PLAN
Includes second dose Epi-Pen® order
SEVERE ALLERGY TO:_

Student Name: School:
Birthdate: _____

Emergency Treatment

If student experiences mild symptoms:
several hives, itchy skin, itchy red watery eyes or nasal symptoms
OR if an ingestion is suspected:

Treatment:

1. Send student to health office **ACCOMPANIED.**
2. **Give of by mouth.**
   (amount and dosage:) (antihistamine)
3. Contact the parent or emergency contact person.
4. **If exposed - Have child wash face, hands and exposed area.**
5. Stay with the student; keep student quiet, monitor symptoms, until parent arrives.
   Watch student for more serious symptoms listed below.

Special Instructions:

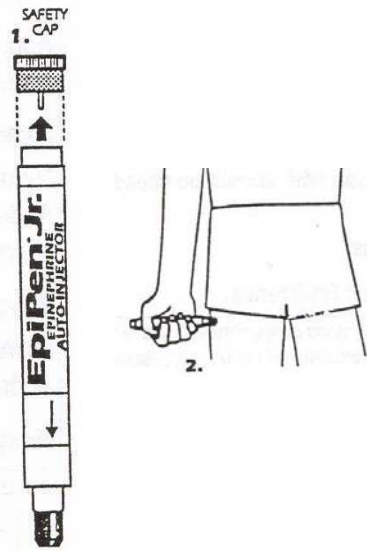
Symptoms that progress and can cause a life threatening reaction:

- *Hives spreading over the body.*
- *Wheezing, difficulty swallowing/ breathing, swelling (face, neck), tingling/swelling of tongue.*
- *Vomiting*
- *Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness.*

Treatment:

1. **Give:** ☐ **Epi-Pen Jr.®** (under 66lbs) **OR** ☐ **Epi-Pen®** (66lbs & over) **immediately**

   Place against upper outer thigh, through clothing if necessary.
2. **Call 911** (or local emergency response team) immediately.
3. Epi-pen® only lasts 20-30 minutes.
   ****Paramedics should always be called if Epi-Pen® is given****
4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.



Directions for use of Epi Pen®:

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi Pen® in impermeable holder using one hand or can and dispose per school policy, or give to emergency care responder.

☐ If symptoms don't improve after _____ minutes, administer second dose following steps 1-5 above.

It is understood by parents and health care provider(s) that this plan may be carried out by school personnel other than the School Nurse Consultant (RN). A RN is to be responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization (Required):_____ Date:_____

Parent/Guardian Signature (Required): _____ Date:_____

□ Parent/Guardian Copy □Student Copy □School Copy □Transportation Copy

HEALTH CARE PLAN
Includes second dose Epi-Pen® order
SEVERE ALLERGY TO:_

Student Name: School:

Birthdate: _____

Allergies (food, insects, medication, etc): **Reaction:**

_____ _____

_____ _____

_____ _____

Diet Restrictions:

For food allergies: ☐ parents will monitor school lunch menus or provide food and communicate with school personnel

☐ student will self monitor food choices

☐ teacher will assist child unable to self select food choices

☐ other

Medications used on a daily basis (include doses):

HOME:

SCHOOL:

REMINDER: School personnel must take Epi-Pen® or any other medication on all field trips.
Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature.
DO NOT FREEZE, refrigerate or keep in extreme heat.

Pertinent Health History (as completed by School Nurse):

EMERGENCY INFORMATION

Parent/Guardian	Number in order of preference		Number in order of preference	
Home Phone:				
Cell Phone:				
Work Phone:				
Pager Number:				
Home Address:				
Emergency Contact:	**Name:**	**Phone:**		
Emergency Contact:	**Name:**	**Phone:**		

Health Care Provider who should be called regarding the allergic reaction:

Name: _____

Phone: _____

Hospital Preference:

If _____ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required)_____ Date _____

School Nurse (RN) Signature: (Required)_____ Date _____

Administrator Signature: (Preferred)_____ Date _____

☐ Parent/Guardian Copy ☐Student Copy ☐School Copy ☐Transportation Copy

Medication Administration Log

Child's Name: _____ **Date of Birth:** _____ **Rm.:** _____

Medication: _____ **Time(s):** _____

Amount:: _____ **Route:** _____ **Start Date for Medication:** _____ **End Date:** _____

Special Instructions: _____

Name of Health Care Provider Prescribing Medication: _____ **Phone:** _____

Parent name: _____ **Parent Work #:** _____ **Parent Home #:** _____

	Week of: Mon Date	Tue Date	Wed Date	Thurs Date	Fri Date	**Week of:** Mon Date	Tue Date	Wed Date	Thu Date	Fri Date
A.M.										
P.M.										

Include Time Medication was Given and Initial box "NG" .

If the child is absent, mark box with an "A" ; If the medication was not given, mark

Document reason medication was not given in Comments.

Date & Comments:

Staff Signatures	**Initials**

Pills Received: **(All controlled medications must be counted, e.g., Ritalin)**

CONTRACT FOR STUDENTS SELF-CARRY OF EPI-PEN®

STUDENT

☐ I plan to keep my Epi-Pen® with me at school rather than in the school health office.

☐ I agree to use my Epi-Pen® in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-Pen® has been used.

☐ I will not allow any other person to use my Epi-Pen®.

Student's Signature _____Date _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

☐ It has been recommended to me that a back-up Epi-Pen® be provided to the Health Office for emergencies.

☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the treatment plan.

Parent's Signature _____Date _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for Epi-Pen® use, an understanding of the physician order for emergency use of the Epi-Pen®.

☐ School staff that has the need to know about the student's condition and the need to carry medication has been notified.

Registered Nurse's Signature _____Date _____

SEVERE ALLERGY DELEGATION RECORD/PROCEDURE GUIDELINES
FOR:
USE OF BENADRYL / EPI-PEN (several delegatees/one child)

Name Student/Child		Birth Date:		School/ Center		RN Instructor: Print Initials:

PROCEDURE GUIDELINE	RN Initials/ Date	RN Initials /Date	RN Initials /Date
1.Confirms written authorization: Parent permission, Physician authorization, up to date Health Care Action Plan			
2. Verifies Epi-Pen® and Benadryl® in pharmacy labeled box Checks expiration dates			
3. Specific Care Training: ▪ Identifies understanding of individual allergy info ▪ Describes S/S of anaphylaxis ▪ Identifies need for Epi-pen® vs. Benadryl® ▪ States importance of monitoring for increased symptoms ▪ Accurately demonstrates administration of Benadryl® ▪ Accurately demonstrates administration of Epi-pen® and proper disposal ▪ Confirms importance of EMS activation ▪ Indicates need/order for second dose of epinephrine			
4. Describes documentation procedure			
5. Identifies process to locate RN			
6. Returns demonstration competently			

I have read the care plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be monitored on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Name (Print)	Delegatee Signature	Date

Delegating RN Signature: _____ Initials _____

SEVERE ALLERGY DELEGATION RECORD/PROCEDURE GUIDELINES
FOR:
USE OF BENADRYL / EPI-PEN (several delegatees/several children)

PROCEDURE GUIDELINE	RN Initials/Date
1.Confirms written authorization: Parent permission, Physician authorization, up to date Health Care Action Plan	
2. Verifies Epi-Pen® and Benadryl® in pharmacy labeled box Checks expiration dates	
3. Specific Care Training: ▪ Identifies understanding of individual allergy info ▪ Describes S/S of anaphylaxis ▪ Identifies need for Epi-pen® vs. Benadryl® ▪ States importance of monitoring for increased symptoms ▪ Accurately demonstrates administration of Benadryl® ▪ Accurately demonstrates administration of Epi-pen® and proper disposal ▪ Confirms importance of EMS activation ▪ Indicates need/order for second dose of epinephrine	
4. Describes documentation procedure	
5. Identifies process to locate RN	
6. Returns demonstration competently	

Student Name	Birthdate	Grade	Identified triggers of severe allergy
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

I have read the care plans, been trained and am competent in the described procedures for the above named students. I understand the need to maintain skills and will be monitored on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Name (Print)	Delegatee Signature	Date

Delegating RN Signature: _____ Initials _____ Date: _____

Medication Administration Instructional Program

Asthma/Inhaled Medications Module

SAMPLE FORMS
Table of Contents

These forms are provided as a resource to the RN instructor for use during the Medication Administration training. Forms may be copied. Please note: the format of these forms may be modified to fit the needs of schools, child care programs and camps as long as the information included on the forms meets the basic requirements outlined in the Instructor Manual.

Asthma Action Plan

American Lung Association

Severity Classification

- ☐ Mild Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Triggers

- ☐ Colds
- ☐ Smoke
- ☐ Weather
- ☐ Exercise
- ☐ Dust
- ☐ Air pollution
- ☐ Animals
- ☐ Food
- ☐ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter

More than 80% of personal best or _____

Peak Flow Meter Personal Best = _____

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

Contact Physician if using quick relief more than 2 times per week.

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ☐ Take quick-relief medication every 4 hours for 1 to 2 days
- ☐ Change your long-term control medicines by _____
- ☐ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used)DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ☐ Take quick-relief treatment again
- ☐ Change your long-term control medicines by _____
- ☐ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Ambulance/Emergency Phone Number:

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

- ☐ Still in the red zone after 15 minutes
- ☐ If you have not been able to reach your physician/health care provider for help
- ☐ _____

Call an ambulance immediately if the following danger signs are present

- ☐ Trouble walking/talking due to shortness of breath.
- ☐ Lips or fingernails are blue

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_____

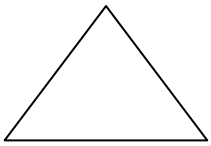
☐Dust and dust mites ☐Strong odors ☐Other:_____

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:

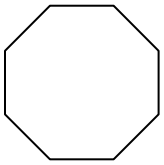
1. Count breaths per minute.
2. Observe for:
   - -Frequent cough, runny nose, stuffy nose.
   - -Increased cough with rapid breathing.
   - -Some decrease in play and/or appetite.
   - -Occasional wheeze you can hear.
   - -Other: _____

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: _____

RESPIRATORY HEALTH CARE PLAN
FOR
SCHOOL AGE (no peak flow meter)

Child's Name_____**DOB** _____
School/Center_____
Triggers: (check those which apply to this child)

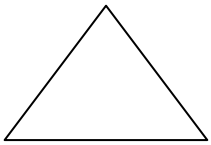
___Weather changes ___Colds ___Cold air ___Exercise
___Pollens (trees, weeds) ___Molds ___Animal dander-Type_____
___Dust and dust mites ___Strong odors ___Other:_____

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

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

Health Care Provider to circle/fill in:
Baseline breaths per minute

16-25 **25-30** _____



Yellow Zone

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:_____

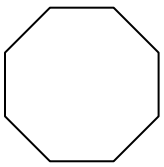
Health Care Provider to circle/fill in:

Greater than:

25 **30** _____ **breaths/min**

Treatment @ child care/school:

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 school nurse and document.



RED ZONE

DANGER

Seek Emergency care if:

- -Continuous coughing, wheezing,
- -Shallow rapid breathing
- -Extremely agitated
- -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
- -difficulty speaking or walking

Health Care Provider to circle/fill in:

Greater than:

40 **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.

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: _____

Teacher's signature: _____ Date: _____

Para's signature: _____ Date: _____

RESPIRATORY HEALTH CARE PLAN

Child's Name: _____ Birth Date: _____

Medication Allergies: _____

Known Triggers to respiratory symptoms:
__ Furry/feathered animals __ Weather changes __ Illness, colds
__ Pollens __ Odors, fumes __ Exercise
__ Other_____

GREEN ZONE (Peak Flow:)

Description: Child's asthma is adequately managed.
No coughing, difficulty breathing, wheezing. Usual activity level
Medications used on a daily basis:

- Name of medication _____
  Give_____ puffs/inhalations/tablet, _____ times per day _____
  To be taken at home / school _____
- Name of medication _____
  Give_____ puffs/inhalations/tablet, _____ times per day _____
  To be taken at home / school / _____ .

Pretreat before exercise with

- Inhaler: Albuterol / Maxair /_____
  Give _____puff(s)/inhalation(s)
  Time: 10-15 minutes before exercise/play.
  End date: _____/ end of school year.

- Albuterol nebulizer treatment
  ___ 0.5 cc of 0.5% solution in 2 cc bronchosaline
  ___ 1 vial of premixed albuterol nebulizer solution
  Time: 10-15 minutes before exercise/play.
  End date: _____/ end of school year

YELLOW ZONE (Peak Flow:)

If any of the following symptoms occur:
___ some coughing ___ some decrease in play and/or appetite
___ some shortness of breath ___ occasional wheeze you may hear
___ some chest tightness ___ _____

Give:

- Albuterol /Maxair / _____, _____ puff(s)/inhalation(s)
  Time: every 4-6 hours
  End date: _____ / end of school year.
- Albuterol nebulizer treatment
  ___ 0.5 cc of 0.5% solution in 2 cc bronchosaline
  ___ 1 vial of premixed albuterol nebulizer solution
  Time: every 4-6 hours
  End date: _____/ end of school year

. _____

1. Encourage child to relax and take deep even breaths.
2. Watch for worsening symptoms.
3. If symptoms continue repeat medicine in 20 minutes.
4. If not improvement with medication, call parents to pick up child for further evaluation.
5. Notify school nurse and document.

RED ZONE (Peak Flow:)

If the following symptoms occur and are not relieved with Yellow Zone treatment:
__ persistent coughing
__ persistent wheezing
__ struggling to breath
__ pulling in of skin around neck muscles, above collar bone, between ribs with each breath
__ difficulty walking or talking due to shortness of breath
__ pale or blueness of lips and/or finger nails

Treatment

- Repeat Albuterol /Maxair / _____, _____ puff(s) every 15 minutes, as needed, up to 3 times

- Repeat Albuterol nebulizer treatment every 15 minutes, as needed, up to 3 times.
  ___ 0.5 cc of 0.5% solution in 2 cc bronchosaline
  ___ 1 vial of premixed albuterol nebulizer solution
- _Other _____
  _____
- Contact parent and school nurse consultant

Call 911 if symptoms don't improve or become worse!

It is understood by the parent/guardian(s) that this plan may be carried out by school personnel other than the school nurse. A registered nurse is to be responsible for delegation of this health care plan to an unlicensed person.

Health Care Provider's Signature: _____
Date: _____
Parent/Guardian Signature: _____
Date: _____

ASTHMA HEALTH CARE PLAN

Student's Name: _____ **Date of Birth:** _____

School/Grade:_____ **ID #:** _____ **Age when asthma diagnosed:** _____

List all routine daily medications (name of medication, dose, and times given):

_____

_____

_____

TRIGGERS: (Check those which apply to this student)

__Exercise
__Colds (viral illness)
__Weather changes
__Cold air weather changes
__Other _____

__Emotions (when upset)
__Irritants: Chalk dust, dust,
__Molds
__Animal dander -Type:_____

__ cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays)
__Pollens (trees, grasses, and weeds)
__Dust and dust mites

SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following

INTERVENTION: Always treat symptoms even if peak flow is not available.

• Coughing • Chest Tightness • Shortness of Breath •Turning Blue •Wheezing •Rapid, labored breathing
• Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone
• Difficulty carrying on a conversation due to difficulty breathing • Difficulty walking due to breathing problems
• Shallow, rapid breathing • Blueness (cyanosis) of fingernails and lips • Decreasing or loss of consciousness
• Other _____

Peak flow meter: Yes ___ No ___ Spacer: Yes ____ No ____

CALL 911 IF THE FOLLOWING OCCUR /PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS ASTHMA HEALTH PLAN

Instructions for Staff:

- Have student stop whatever they are doing
- Send the student to the clinic when experiencing respiratory difficulty as described above

If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

Directions for self-medication:

_____ (initial if applicable). Signatures of the parent/guardian and the physician(see reverse side) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.

Field Trips:

- Medications and peak flow meter MUST accompany student on all field trips.
- A copy of this Health Care Plan and current phone numbers MUST be with staff member
- Teacher Must be instructed on correct use of asthma medications

(Emergency contact information and Peak Flow Meter Guidelines on reverse side)

ASTHMA HEALTH CARE PLAN

Parents/Guardian: _____
Address: _____ Home Phone: _____ Work Phone: _____

Alternate contacts if parent cannot be reached:
Name: _____ Name: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____

Physician who should be called regarding asthma:
Name: _____
Phone: _____ Fax: _____

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

GREEN ZONE - Good control >>>>>>>>>>>>>>

- No cough or wheeze
- Tolerating activity easily

Peak flow **above** _____
Indicates that student's asthma is under good control.
This is where he/she should be every day

Treatment Plan:

1) Daily School Meds: **Circle one**: Albuterol / Other:
_____

2) Use before exercise/physical activity: Yes ___ No ___

3) Other:

YELLOW ZONE - Worsening Asthma > > > > > > >

- Worsening symptoms
- More short of breath with activity
- Need reliever inhaler more often than usual

OR

Peak flow between ____ and _____
Indicates a warning that student's asthma may flare unless additional measures are taken.

Treatment Plan:

1) Reliever inhaler: **Circle one:** Albuterol / Other:
_____

2) Recheck peak flow 10 minutes after treatment
May return to class if symptoms or peak flow improve. Vigorous activity should be avoided.
May repeat inhaler if no improvement in 20 min:
Yes _____ No_____

3) **Call parent** to inform of situation.

4) If student is not improving or getting worse, follow Red Zone plan.

RED ZONE - Danger zone >>>>>>>>>>>>>>

- Getting little relief from inhalers

OR

- Peak flow **below** _____
- More breathless despite increased medications
  Peak flows do not respond to reliever inhaler/nebulizer
  This is student's danger zone.

Treatment Plan:

1) **Call parent** to inform of urgent situation.

2) If symptoms continue to be severe and/or parents aren't available call **911 immediately**

3) **Urgent Medications:** _____
(include dosage)

1) As parent/guardian of _____ , I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2) It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3) This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician Signature: _____ Date: _____
Parent Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____
Student Signature: _____ Date: _____

Medication Incident Report

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

Student's Name: _____ Grade: _____ School: _____

Name of Medication/Dose_____Time:_____Route_____

Date and Time Incident Discovered: _____

Person Completing this Form: _____

Please describe the INCIDENT below. Always inform the school nurse or nurse consultant 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 written orders signed and dated by parent and doctor?		
Right procedure? Other: _____ _____ _____		__ Parent Notified - date _____ time _____ __ Nurse Notified - date _____ time _____ __ Principal or Director Notified -date _____ time_____ __ 911 or Poison Control

Nurses Comments/Corrective Action Taken:

Signature of School Nurse: _____ Date: _____

This form adapted from a form provided by Aurora Public Schools, Aurora, CO

PROCEDURE GUIDELINE AND COMPETENCY CHECKLIST FOR INHALER

Name Student/child | Birth Date: | School/ Center: | Delagatee:

PROCEDURE GUIDELINE	Training Date/ RN Initials	Training Date/ UAP Initials	Return Demonstrations		
			Date/ RN + UAP Initials	Date/ RN + UAP Initials	Date/ RN + UAP Initials
A. States name purpose of procedure 1. Verifies parent authorization, health care provider authorization, and health care plan.					
B. Preparation:					
1. Reviews universal precautions 2. Identifies equipment and supplies needed • inhaler • spacer • mask adapter or mouthpiece					
C. Procedure:					
1. Washes hands					
2. Gathers supplies/equipment near child					
3. Positions child in an upright comfortable position and explains procedure					
4. Checks written instructions/authorizations					
5. Checks when last treatment given					
6. Observes, counts and documents the child's respiration rate.					
7. Attaches mask or mouthpiece to spacer					
8. Attaches inhaler to spacer and mask or mouthpiece.					
9. Places mask over child's mouth and nose or mouthpiece into child's mouth and dispense medication.					
10. Observes child for reactions to treatment					
11. Observes, counts, and documents child's respiration rate.					
12. Documents procedure and observations					
13. Reports any changes to family					
14. Rinses spacer, mask under hot running water. Allows pieces to air dry on clean paper towel or cloth. Stores in clean plastic bag when dry.					

Competency Statement: Describes understanding of the need for inhaled medication for an infant, demonstrates proper use of inhaler, spacer and mask and identifies problem-solving ability in the event of child/equipment difficulties.

Delegatee Signature _____ Initials _____

Training RN Signature: _____ Initials _____

DELEGATION AUTHORIZATION I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Delegation Decision Grid Score _____ Date _____

Delegating RN Signature: _____ Initials _____ Date _____

RE-DELEGATION AUTHORIZATION I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Delegation Decision Grid Score _____ Date _____

Delegating RN Signature: _____ Initials _____ Date _____

RE-DELEGATION AUTHORIZATION I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Delegation Decision Grid Score _____ Date _____

Delegating RN Signature: _____ Initials _____ Date _____

PROCEDURE GUIDELINE AND COMPETENCY CHECKLIST FOR NEBULIZER

Name Student/child | Birth Date: | School/ Center: | Delagatee:

PROCEDURE GUIDELINE NEBULIZER	Training Date/ RN Initials	Training Date/ UAP Initials	Return Demonstrations Date/ RN + UAP Initials	Date/ RN + UAP Initials	Date/ RN + UAP Initials
A. States name purpose of procedure					
B. Preparation:					
1. Reviews universal precautions 2. Identifies equipment and supplies needed ▪ nebulizer machine • nebulizer cup ▪ connection tubing • mouth piece or mask ▪ medication and normal saline or pre-measured medicine					
C. Procedure: 1. Washes hands					
2. Gathers supplies/equipment near child and power source					
3. Positions child in an upright comfortable position and explains procedure					
4. Checks written instructions/authorizations					
5. Checks when last treatment given					
6. Observes, counts and documents the child's respiration rate.					
7. ☐Measures _____ of _____ and _____cc of saline into the nebulizer cup. ☐ Empties premixed unit dose into nebulizer cup.					
8. Attaches ☐ mouthpiece or ☐mask to nebulizer cup.					
9. Attaches nebulizer tubing to the air compressor and the nebulizer cup.					
10. Turns nebulizer on and checks for mist.					
11. ☐Places mouthpiece in child's mouth and instructs child to breathe in and out through mask ☐ Places mask over child's mouth and nose.					
12. Observes child for reactions to treatment and encourages slow deep breaths.					
13. Checks nebulizer cup to ensure that all medicine is given.					
14. Turns machine off when treatment is finished.					
15. Observes, counts, and documents child's respiration rate.					
16. Instructs or assists child with hand washing and drinking water to rinse mouth.					
17. Documents procedure and observations					
18. Reports any changes to family					
19. Rinses cup, mouthpiece/mask under hot running water. Allows pieces to air dry on clean paper towel or cloth. Stores in clean plastic bag when dry.					

Competency Statement: Describes understanding of the need for nebulized medication, demonstrates proper use of nebulizer and identifies problem-solving ability in the event of student/equipment difficulties.

Delegatee Signature _____ Initials _____

Training RN Signature: _____ Initials _____

DELEGATION AUTHORIZATION I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Delegation Decision Grid Score _____ Date _____

Delegating RN Signature: _____ Initials _____ Date _____

RE-DELEGATION AUTHORIZATION I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Delegation Decision Grid Score _____ Date _____

Medication Administration in School or Child Care
Nebulizer treatments or inhaled medications

Parent or Guardian Permission

The parent/guardian of _____ **ask that school/child care staff give the**
(Child's name)

following medication _____ **at** _____
(Name of medicine and dosage) (Time)

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's responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

By signing this document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with Program staff.

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

_____ _____
Home Phone Work Phone

Health Care Provider Authorization

Child's Name _____ Birthdate: _____

Name of inhaled medication: _____

Dosage: _____

To be given in school/child care at the following time(s): _____

***Note to health care provider:* Specific time and/or interval must be indicated on this form in order for non-medical persons in school/child care to administer medication**

Start Date:_____ End Date: _____

Usual (baseline) respiratory rate for this child: _____

Comments: _____

Seek Emergency Medical Care if the child has any of the following:

- Respiratory rate greater than _____
- Coughs constantly
- Hard time breathing with:
  - ✔ Chest and neck pulled in with each breath
  - ✔ Struggling or gasping for breath
- Trouble walking or talking
- Lips or fingernails are grey or blue
- Other _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority Phone

NEBULIZER TREATMENT LOG

Child's Name _____ Classroom: _____

Medication & dosage: 1._____ Time(s) to be given:_____

2._____ Start date:_____ End date:_____

Special Instructions: _____

Daily reminder: *Ask the parent/guardian the time of the last treatment.*
Nebulizer treatments should not be given more often than every 4-6 hours. Be sure to follow written medical instructions.

Date	Time of last neb Given at home	Time	Breath rate per minute: before	Breath rate per minute: after	**Observations:** (Cough, skin color, secretions, any discomfort, activity level, etc.)	Staff initials

Comments:

Staff signature and initials: _____ _____

_____ _____

Normal breathing rate at rest:

Infant < one year 20-40 breaths/minute Toddler: 18-30 breaths/minute School age child: 16-25 breaths/minute

NEBULIZER TREATMENT PROCEDURE

Equipment includes:

- nebulizer machine nebulizer "cup" with mouth piece or mask
- medication and normal saline (or pre-measured medicine)
- nebulizer machine
- connection tubing

- Check written instructions from the primary health care provider.
- Check written permission from the child's parent/guardian
- ***Find out what time the last treatment was given by the parent****. Ask the parent "how the child is feeling, sleeping, eating and activity level".*
- Perform a "daily health check" of the child when the child arrives in the classroom.
- Notify the RN consultant if this is a new nebulizer treatment and review child's plan of care.
- Observe, count, and document the child's breathing before treatment.

1. Wash your hands.
2. Observe, count, and document the child's breathing rate.
3. Assemble the equipment near the child and a power source.
4. Measure and pour the medicine into the nebulizer cup. *Note: medications may come in a "unit dose" (saline and medication are premixed)*
5. Have the child sit in an upright comfortable position.
6. Attach the nebulizer tubing to the air compressor and turn it on.
7. Place the mouthpiece into his mouth. The child needs to breathe in and out through his mouth. A mask may be used for infants and young children.
8. Observe the child for any reactions such as wheezing. If the child coughs during the treatment, remove the mouthpiece or mask, and allow the child to finish coughing.
9. When the treatment is finished, turn off the machine.
10. Observe, count, and document the child's breathing rate
11. Report to the parent if the child's breathing rate is above their normal rate. See the health care plan or written instructions from the health care provider.
12. Ask child to wash their hands and drink water to rinse out their mouth.
13. Wash your hands.
14. **DOCUMENT:** Date, time, number of breaths per minute before and after the treatment, any observations (i.e. cough, secretions, skin color, activity, etc.). Initial and sign the log. *Note: Some children cough up mucous after breathing treatments. Observe the color and thickness. Normal secretions are usually white/clear and thin. Thick and sticky mucous that is yellow or green color may indicate infection. Report this to the parent.*
15. **CLEANING:** rinse the "cup", mouthpiece/mask under hot running water. Allow the pieces to air –dry on a clean paper towel or cloth. When dry, store in a clean plastic bag that can be closed. A more complete cleaning is needed if more than 3-4 treatments are given per day. Note: Do not clean tubing.

Send the nebulizer machine/equipment home with parent for regular maintenance.

Normal breathing rate at rest:

Infant < one year 20-40 breaths/minute **Toddler: 18-30 breaths/minute** **School age child: 16-25 breaths/minute**

The Children's Hospital School Health Program, Denver, CO 2006

CONTRACT FOR STUDENTS CARRYING INHALERS WITH THEM WHILE AT SCHOOL

STUDENT

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the treatment plan.

Parent's Signature _____Date _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that has the need to know about the student's condition and the need to carry medication has been notified.

Registered Nurse's Signature _____Date _____

About The Sample Forms Packet:

The packet of sample forms can be emailed for free or purchased at $5.00 by calling (303) 914-6307