Overnight Field Trip – Student Health Concerns Packet

Dear 5th Grade Parent/Guardian,

Your child is scheduled to attend an overnight excursion to the Denver Public Schools Balarat Outdoor Education Center. This will be an exciting time and we want to ensure it will be a safe experience for all.

Please follow the instructions in this packet and ensure forms are turned in by the dates listed at the bottom of this page to ensure your student is able to attend.

- The Health Information Sheet, the colored form in this packet, must be returned to homeroom teacher by the date below. **All students must return this form even if there are no medical concerns.**

- If you answered "Yes" to any of the questions you will need to fill out one or more of the Medication forms listed below. These forms are to be completed and signed by both a parent and a doctor for any/all medications needed. Completed and signed medication forms must be turned into the health office by the date listed below. *These dates are nonnegotiable* as our nurse is only in the building limited days/times to review all information and ensure staff members are properly trained.

    - The Medication Release Form is used for all medications – prescription and over the counter that your student will need while on the excursion. Please note that we must have a form signed by a doctor for every medication including over the counter meds such as Tylenol, Motrin, Benadryl, Tums etc.

    - The Asthma Care Plan needs to be completed if your student has asthma or needs an inhaler. If we already have an Asthma care plan on file for this school year, we do not need an additional form.

    - The Allergy and Anaphylaxis Emergency Care Plan must be completed for any student requiring an EPI –PEN. Please note an additional medication release form must be included for an Antihistamine (Benadryl) if the doctor lists the Antihistamine on the anaphylaxis form.

- All medications must be brought into the health clinic by the date listed below. **PLEASE NOTE:** All medications must be in prescription labeled container – this includes inhalers, epi-pens etc. We cannot accept a medication without the prescription label. Over – the -counter medications must have a doctor order and be in a sealed, original container with student's full name written on container. *These dates are nonnegotiable* as our nurse is only in the building limited days/times to review all information and ensure staff members are properly trained.

If you have any questions please contact April Thompson, our DGS Health Tech at 720-424-7491 or april_thompson@denvergreenschool.org

DUE DATES:

-Health Information Form - **Friday, January 15th 2016**
-Medication Forms –completed by parent and doctor – **Thursday, January 28th 2016**
-Medications turned into DGS Health Tech/Nurse – **Thursday, February 4th 2016**

Overnight Field Trip – Health Information Sheet
All students must turn in this form

Complete this form and return it to classroom teacher **by Friday, January 15th 2016**

The completed medication release forms (completed by subscribing Dr. and parent) must be turned in to health tech by **Thursday, January 28th 2016**

Medications in prescription labeled containers or sealed and labeled over the counter container must be turned in to the health tech by **Thursday, February 4th 2016**

Student Name:_____ Homeroom Teacher:_____

Parent Name:_____ Contact Number:_____

Does your child *need* to take any medication while on this trip? Yes _____ No_____
(To include: Inhalers, allergy pills, 'tylenol', ibuprofen,)

Does your child need any emergency medications: Inhalers, EPI, Seizure Meds etc. Yes_____ No_____

Are there any medical or other health conditions we should be aware of (please include any allergies):_____
_____

If yes to above, please list all medications that will need to be taken:

Medication	For what condition?	Dose	Time to be Given

All Medications:
Must have the student's name on the prescription
Must have a signed consent from the parent/guardian and Prescribing Health Care Provider
All medication must be turned in to the Health Tech to carry for the field trip.

Thank you for your assistance,
April Thompson
Health Tech, Denver Green School
720-424-7491

*** **ALL students must turn in this form*****. The remaining forms in this packet only pertain to students needing medications for the field trip.

DENVER PUBLIC SCHOOLS
DIVISION OF STUDENT SERVICES
NURSING & STUDENT HEALTH SERVICES
2015/2016

School: _____

Phone: _____

FAX: _____

STUDENT MEDICATION REQUEST RELEASE AGREEMENT

The undersigned parent(s) or guardian(s) of:

Name of Student _____ Date of Birth ____/____/____ hereby request school staff(s) employed by the Denver Public School District to administer to said child the medication or treatment as described by the prescribing Primary Care Provider's (PCP) signed instructions below.

In compliance with School District Policy JLCD- Administering Medicines to Students, which requires as a condition to its agreement to administer any medication, that the medicine has been prescribed by a PCP or dentist and that it has been furnished by the parent/guardian(s) of the student with the original pharmacy container label stating the child's name, name of the medication, the dosage, the route, the number of dosages per day or time(s) and the date when the medication is to be discontinued (if applicable). This applies to all medications including over the counter. It is understood that the medication is given solely at the request of and as an accommodation to the undersigned parent/guardian(s). The undersigned parent/guardian(s) hereby agree(s) to release the Denver Public Schools and its school staffs from any and all claim(s) which they now have or may hereafter have arising out of the administration of, or failure to administer, the medication to the student. At no time will any school staff(s) recommend or require the student be prescribed psychotropic medication(s) to attend school.
By signing, the parent/guardian agrees that Denver Public Schools Staff, including the Manager of Nursing Services or the school nurse at the student's school may contact outside providers for further information about the student's medical needs. It is also agreed that the outside provider is granted permission to release confidential information to DPS staff. It is understood that this information will be kept confidential, and will be used only for the purpose of making a decision about the relevance of the Medical Accommodation Plan to the educational needs of the student.

PLEASE NOTE: For medication to be given at home and school, please ask the pharmacist for a separate, accurately labeled medication bottle to be kept at school.
BE ADVISED: It is the Parents/Guardians responsibility to pick up student medication by student dismissal the last day of the school. Medications left unclaimed will be disposed of according to the Colorado Department of Human Services (CDHS) "Guidelines for Medication Administration (2008)."

_____ _____
Signature of Parent or Guardian Month/Day/Year

PRIMARY CARE PROVIDER (PCP) SIGNED ORDER FOR MEDICATION

This form must be completed for any medication a student will need to take during school hours.
Please be aware that any medications, including samples, must have a medication label to be administered at school.

Student's Name: _____ Grade: _____ Date of Birth: ____/____/____

Medication Name (*one per form*) _____ Dosage: _____

Route: _____ Frequency: _____ Times given at School: _____

Starting date: ____/____/____ Ending date: ____/____/____ or until end of school year 2015-2016

Purpose of Medication: _____ Allergies: NKDA Other: _____

Possible Side Effects: _____

_____ Phone: _____ Fax: _____
(Print) Name of PCP or Dentist Prescribing Medication

_____ Date: ____/____/____ Clinic Name: _____
Signature of PCP w/Prescriptive Authority

Medication Discontinued: Time: _____ and Date: ____/____/____ PCP Signature: _____

_____ / _____ Date: ____/____/____
(Print) Name of School Nurse Signature of School Nurse

School Nurse Signature indicates that the medication and medication orders have been reviewed by School RN

05/15

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

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

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

☐ Life threatening allergy : Specify _____

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

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____ _____ _____ ☐ 504 PLAN OR IEP

PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

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

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

Pretreatment for strenuous activity: ☐ Not Required

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

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

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

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

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

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

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

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

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

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

_____ _____ _____ _____

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

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

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____
School: _____ Teacher: _____
ALLERGY TO: _____
HISTORY: _____
_____
Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

Place child's photo here

◊ STEP 1: TREATMENT

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

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

→

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

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

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

→

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

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve in_____minutes, or if symptoms return, 2nd dose of epinephrine should be given, if available.

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler: (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____