

Dear Parents and Guardians:

Welcome to the 2022-2023 school year at Thomas MacLaren School! Every year it is helpful for us to have an update to our records if your child/ren have asthma, allergies, celiac disease, diabetes, migraines, seizures or any other health care issue. This allows us to better care for your child/ren throughout the school year and helps decrease the number of interruptions to their learning due to illness or complications from their health concerns.

All of the forms included in these health care plans (HCPs) must be filled out completely by either you or a health care provider with prescriptive authority. Please note that both the parent/guardian and the health care provider need to sign the documents.

If your child/ren will need to carry a rescue inhaler, Epi-Pen®, or diabetes supplies with them this year, then please fill out the Contract to Carry form and return to the front desk prior to sending your child/ren to school with their medication. Unfortunately, we are no longer able to administer your child/ren's emergency medication without a signed HCP and a completed Authorization for the Administration of Medication by School Personnel.

For your reference, all of the links for these forms and packets can be found on the school website: www.maclarenschool.org under the Parent tab in the Health Information section.

Thank you for letting us partner with you to make sure that your child/ren have a healthy and safe school year. If you have any questions or concerns, please don't hesitate to contact me.

Kind Regards,

Terra Fisk, RN, BSN | School Nurse

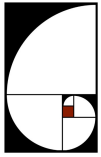
Thomas MacLaren School

1702 N. Murray Blvd.

Colorado Springs, CO 80915

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719.313.4488 | Secure Fax: 866.587.2608



MIGRAINE / HEADACHE
HEALTH CARE PLAN

Student : _____ Effective Date: _____

Student DOB: _____ School Nurse: _____

Doctor: _____ Neurologist: _____

Parent: _____ Special Ed? 504?: _____

Medications taken daily at home: _____

Medications taken as needed at school or at home: _____

Headaches symptoms account for many visits to the health room and phone calls to parents. While many headaches may be painful, often they do not constitute a serious problem. Tension headaches, characterized by scalp or neck pain or a feeling of a “tight band” around the head are often caused by stress or poor posture. The “classic” migraine headache is characterized by an aura (warning of impending migraine), such as numbness of the face or arm, tingling sensations, or visual changes. Following the aura, pain frequently occurs on one side of the head. Light sensitivity may worsen the headache. The cause of migraines is not exactly known but appears to involve chemical changes that make the blood vessels in the brain constrict and dilate. Triggers may include stress, fatigue, overwork, menstruation, and dietary intake (caffeinated drinks, chocolate, or cheese).

Triggers: _____

Symptoms: _____

Problem: Pain

Goal: Relieve discomfort

Action:

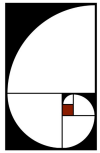
1. Administer medication, as prescribed:
 - A. Medication, if given during the aura, may prevent or decrease the pain.
 - B. Side effects that must be reported to the school nurse and parents include: _____
2. Allow student to rest in the health room for at least 20 minutes.
 - A. If there is no improvement or if the headache worsens, then the student will take 2nd medication, if available.
 - B. Parent will be contacted.
3. Document headache symptoms, length of symptoms, time symptoms began, any precipitating factors, and actions taken.

Health Care Provider Signature and Date

Parent Signature and Date

School Nurse Signature and Date

**This Health Plan and any nurse delegation related to this plan are for use during normal operational school hours. After hours: call parent(s) and/or 911 for medical concerns/emergencies.



**HEALTH CARE PROVIDER'S AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION
BY SCHOOL PERSONNEL**

Dear Parent:

If your child must have medication of any type, including over-the-counter medicine, given during school hours, you may:

1. Come to the school and administer it to your child at the appropriate time; or
2. Discuss with your health care provider an alternative schedule to administer medications outside of school hours; or
3. Complete, in its entirety, the attached form signed by your Health Care Provider (with prescriptive authority) and Parent; AND
4. Provide the medication in the original labeled pharmacy container which includes the child's name, name of medicine, specific dosage amount (such as 2 tabs/tsp/puffs every 4 hours - NOT a range such as 1-2 tabs/tsp/puffs every 4-6 hours), and instructions for administration. For over-the-counter medication, please provide the medicine in a new, unopened bottle with all labels AND write the Student's full name on the bottle/container.

Remember, staff at Thomas MacLaren School may only administer medications at school with the properly completed documentation and the medication in the original, properly labeled container. Non-FDA approved substances, including herbs, supplements, essential oils, etc., will NOT be administered at school.

Thank you,

Terra Fisk, RN, BSN | School Nurse

Phone 719.313.4488 | Secure Fax: 866.587.2608

1702 N. Murray Blvd., Colorado Springs, CO 80915

Students required to take medication(s) prescribed by a physician during regular school days may be assisted by the school nurse or other designated school personnel. Medications may be administered only if the school receives specific written instructions from the physician and parent/guardian of the student.

Authorization to Assist in Administration of Medication

Student: _____ Birthdate: _____ Grade: _____

Purpose of medication: _____ Possible Side Effects: _____

Medication: _____ Dosage: _____ Route: _____

Time of day to be given at school: _____ Start Date: _____ End Date: _____

Asthma Inhaler / Epi-Pen (must also have self-carry contract): This student **MAY/ MAY NOT** carry their own Inhaler / Epi-Pen..

Physician Office Number & Fax Number: _____ Physician Signature/Stamp: _____

Parent Request that School Administer Medication

I request that medication be administered to my child by the designated member of the school staff in accordance with the instructions on the Health Care Providers's authorization. Please give my child their medication according to the above authorization,. Any special instructions are noted here: _____

It is understood that the medication is administered solely at the request of, and as an accommodation to, the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Thomas MacLaren School, the undersigned parent/guardian hereby agrees to release Thomas MacLaren School and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I will notify the school **immediately** if the medication is to be changed or terminated, or if we change health care providers.

I hereby give my permission for: (name of student).. _____ to take the above named prescription at school as ordered.

Date: _____

Parent/Guardian Signature: _____