



Evergreen Park & Recreation District Medication Forms Fill  
out forms that apply to your child(ren)



Evergreen Park & Recreation District 2023

## Medication Paperwork

**These forms need to be completed and turned in to the  
supervisor of the camp you are signed up for.**

The Medication packet is mandatory for any medication that would  
be given during program hours.

Please be aware that same day drop off for medication is not acceptable.

Please allow at least 5 business days for medications plans to be approved.



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**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!



# Evergreen Park & Recreation District Medication Forms

## Fill out forms that apply to your child(ren)

Photo of child

### COLORADO SCHOOL ASTHMA CARE PLAN

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen  
Other: \_\_\_\_\_

### GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider please complete section)

- ☐ Give 2 puffs of rescue med (*name*) \_\_\_\_\_ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation: \_\_\_\_\_  
☐ Repeat in 4 hours if needed for additional or ongoing physical activity

### YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue medication)

#### IF YOU SEE THIS:

- Difficulty breathing
- Wheezing
- Frequent cough
- Complaints of chest tightness
- Unable to tolerate regular activities but still talking in complete sentences
- Other: \_\_\_\_\_

#### DO THIS:

- Stop physical activity
- Give rescue med (*name*): \_\_\_\_\_  
☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ other: \_\_\_\_\_
- If no improvement in 10-15 minutes, repeat use of rescue med:  
☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ other: \_\_\_\_\_
- If student's symptoms do not improve or worsen, call 911
- Stay with student and maintain sitting position
- Call parents/guardians and school nurse
- Student may resume normal activities once feeling better

#### ▪ If there is **no rescue medication at school**:

- 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

### RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

#### IF YOU SEE THIS:

- Coughs constantly
- Struggles or gasps for breath
- Trouble talking (can speak only 3-5 words)
- Skin of chest and/or neck pull in with breathing
- Lips or fingernails are gray or blue
- ↓ Level of consciousness

#### DO THIS IMMEDIATELY:

- Give rescue med (*name*): \_\_\_\_\_  
☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other: \_\_\_\_\_
- Repeat rescue med if student not improving in 10-15 minutes  
☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other: \_\_\_\_\_
- Call 911 Inform attendant the reason for the call is asthma
- Call parents/guardians and school nurse
- Encourage student to take slower deeper breaths
- Stay with student and remain calm
- *School personnel should not drive student to hospital*

#### INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE 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  
☐ Student is to notify his/her designated school health officials after using inhaler  
☐ Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located: \_\_\_\_\_  
☐ Student has life threatening allergy, the epipen is located: \_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE

PLEASE PRINT PROVIDER'S NAME

DATE

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.

PARENT SIGNATURE

DATE

☐ 504 Plan or IEP

School Nurse Signature

DATE

Copies of plan provided to: Teachers \_\_ Phys Ed/Coach \_\_ Principal \_\_ Main Office \_\_ Bus Driver \_\_ Other \_\_\_\_\_

RNS Cadre March 2010

02/2023



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**FARE**

Food Allergy Research & Education

**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs.

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

**For a suspected or active food allergy reaction:**

PLACE  
STUDENT'S  
PICTURE  
HERE

FOR ANY OF THE FOLLOWING  
**SEVERE SYMPTOMS**

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.



**LUNG**

Short of breath, wheezing, 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 or severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of mild or severe symptoms from different body areas.

**NOTE:** Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. Use Epinephrine.

**1. INJECT EPINEPHRINE IMMEDIATELY.**

**2. Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

**NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.**

**MILD SYMPTOMS**

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.



**NOSE**

Itchy/runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea/discomfort



**1. GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**

- Stay with student; alert emergency contacts.
- Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

**MEDICATIONS/DOSES**

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013





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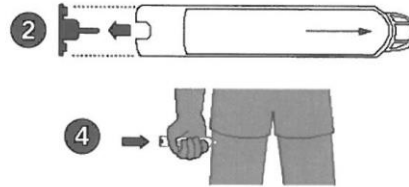


**FARE**  
Food Allergy Research & Education

**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

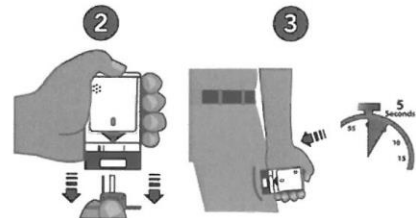
**EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



**ADRENALICK®/ADRENALICK® GENERIC DIRECTIONS**

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



**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

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