

**CHERRY HILLS COMMUNITY CHURCH
CARE PLAN AGREEMENT 2018-2019**

Cherry Hills Christian (CHC) are ministries of Cherry Hills Community Church ("CHCC"). This Care Plan Agreement ("Agreement") made and entered into this day, the _____ of _____, 20____ is between Cherry Hills Community Church and _____ as parent(s) or legal guardian(s) ("Parents") of _____ ("Child").

Recitals

1. CHCC operates CHC to provide children with a Christ-centered education experience.
2. While not required by law, Cherry Hills Community Church believes that providing education to children with disabilities or health risks is consistent with Scripture and with the broader mission of the church.
3. The Parents acknowledge that the Child's health condition and/or disability exposes the Child to some level of risk as a participant in the programs.
4. Cherry Hills Community Church is willing to consider admitting the Child if they can be assured that the staff can administer the Child's unique type of care.

Agreement

Now, therefore, if full consideration and acceptance of the foregoing, as well as other vital aspects of this matter, the parties hereto agree as follows:

1. The Care Plan, which at a minimum will contain the Care Plan Agreement, Medication Release and Parent Information form, sets forth the requisite standard of care required for the Child to attend CHC. The Parents in consultation with the Child's physician have prepared the Care Plan.
2. Cherry Hills Community Church shall rely upon the Care Plan as adequate to address the Child's health needs and minimize risk to the child while participating in programs at Cherry Hills Community Church.
3. The Parents, being fully mindful of the risks to the Child, exempt and release Cherry Hills Community Church, its officers, agents and employees from any and all liability, claims, demands, actions or causes of action whatsoever arising out of any injury to the Child resulting from the administration of the Care Plan.
4. For its part, Cherry Hills Community Church agrees to implement the Care Plan, but makes no representations as to any special medical training or expertise of its employees relating to the administration of such care.
5. The Parents acknowledge that Cherry Hills Community Church is acting in complete reliance that the Care Plan, as written, substantially eliminates the risk to which the Child is exposed by attending CHC. Parents shall immediately give written notice to the school nurse of any changes in Child's condition.
6. Cherry Hills Community Church in its sole discretion may terminate the Child's enrollment at any time, for any reason, if they deem the degree of risk, by the Child's continued enrollment, has become unacceptable.
7. It is understood that Care Plan information will be shared with appropriate CHC personnel in order to provide a safe and supportive school experience.

In witness whereof, the parties below have executed this Care Plan Agreement on the date stated above.

CHC Principal/Director

Parent/Guardian

CHC School Nurse:

Parent/Guardian

Both parents/guardians must sign

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) – refer to their asthma care plan
 NO

◇ STEP 1: TREATMENT ◇

SEVERE SYMPTOMS: Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation



MILD SYMPTOMS ONLY:

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



1. **INJECT EPINEPHRINE IMMEDIATELY**
 2. Call 911
 - Ask for ambulance with epinephrine
 - Tell EMS when epinephrine was given
 3. Stay with child and
 - Call parent/guardian and school nurse
 - If symptoms don't improve or worsen give second dose of epi if available as instructed below
 - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side
- Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

1. Stay with child and
 - Alert parent and school nurse
 - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and 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 ___ minutes or more, or 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: _____

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, call 911. State that an anaphylactic 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) _____

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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

Staff trained and delegated to administer emergency medications in this plan:

- 1. _____ Room _____
- 2. _____ Room _____
- 3. _____ Room _____

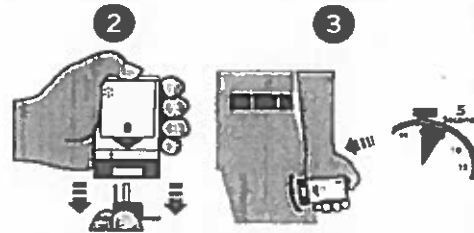
Self-carry contract on file: Yes No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

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.



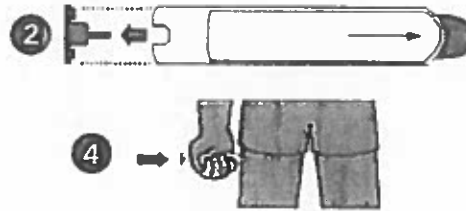
ADRENALICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

- 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 enters thigh.
- 5. Hold in place for 10 seconds. Remove from thigh.



EPIPEN® AUTO-INJECTOR DIRECTIONS

- 1. Remove the EpiPen Auto-Injector from the clear carrier tube.
- 2. Remove the blue safety release by pulling straight up without bending or twisting it.
- 3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
- 4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
- 5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disability if required by district policy.

Additional information: _____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN: School/grade: _____
 Child Name: _____ Birthdate: _____
 Parent/Guardian Name: _____ Phone: _____
 Healthcare Provider Name: _____ Phone: _____
 Triggers: Weather (cold air, wind) Illness Exercise Smoke Dust Pollen Other: _____
 Life threatening allergy, specify: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE		DATE	NURSE/CCHC SIGNATURE	DATE
HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:		QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ Common side effects: <input type="checkbox"/> ↑ heart rate, tremor <input type="checkbox"/> Have child use spacer with inhaler. Controller medication used at home: _____		
IF YOU SEE THIS:		DO THIS:		
GREEN ZONE: No Symptoms Pretreat	<ul style="list-style-type: none"> • No current symptoms • Doing usual activities 	Pretreat strenuous activity: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Repeat in 4 hours, if needed for additional physical activity. <i>If child is currently experiencing symptoms, follow YELLOW ZONE.</i>		
YELLOW ZONE: Mild symptoms	<ul style="list-style-type: none"> • Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: _____ & _____ 	1. Stop physical activity. 2. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 3. Stay with child/youth and maintain sitting position. 4. REPEAT QUICK RELIEF MED, if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. <i>If symptoms do not improve or worsen, follow RED ZONE.</i>		
RED ZONE: EMERGENCY Severe Symptoms	<ul style="list-style-type: none"> • Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • ↓ Level of consciousness • Peak flow < _____ 	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, REPEAT QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs every 5 minutes until EMS arrives. <i>School personnel should not drive student to hospital.</i>		

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

Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.
 Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.
 Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER NAME _____ DATE _____ FAX _____ PHONE _____

Copies of plan provided to: Teacher(s) PhysEd/Coach Principal Main Office Bus Driver Other _____



CHERRY HILLS CHRISTIAN: PRESCHOOL - ELEMENTARY - MIDDLE

STUDENT MEDICATION RELEASE AGREEMENT 2018-2019

ONLY ONE MEDICATION PER PAGE

OTHER MEDICATIONS NEEDED DURING SCHOOL HOURS

Student Name: _____

CHC policy requires all of the following conditions must be met before any medication can be given to your student:

- All medicines must be prescribed by a physician or dentist
- All medicines must be provided by the parent/guardian
- **All medicines must be presented in its original pharmacy/pharmaceutical labeled container**
- **Please have pharmacy label EACH EpiPen individually.**
- Each pharmacy generated label must provide the following minimal information
 - a. Name of child
 - b. Name of medication
 - c. Prescribed dosage (including time of day if applicable)
 - d. Date the medicine is to be discontinued

The undersigned parent/guardian understands that the request for the administration of the below named medication is agreed to solely as an accommodation. Therefore, the undersigned agrees to release CHC and their personnel from any and all current or future claims arising out of the release or failure to release such medication to the student. Undersigned agrees to give consent to nurse to contact physician with questions or concerns regarding medication.

Parent/Guardian's Signature

Date

Parent/Guardian's Signature

Both parents/guardians must sign

Date

(Printed Name of Physician/Dentist)

(Physician's/Dentist's Telephone Number)

PHYSICIAN'S SIGNED ORDER FOR MEDICATION

This form must be completed for ANY MEDICATION (prescription or non-prescription) a student will take during school hours.

Student Name

Medication (Epinephrine is on a separate form)

Dosage

Route of Administration

Frequency/Time

Start Date

Discontinue Date

(All medications expire at the end of school year)

Purpose of Medication

Side Effects of Particular Concern

Physician's Signature

Date

Phone

This completed form may be faxed to CHC School Clinic at 303-325-8132

Revised 05-09-18

MIDDLE SCHOOL ONLY

**PERMISSION TO CARRY MEDICATIONS AT SCHOOL
2018-2019 School Year**

_____ has been instructed in the proper use of
Student's Name

_____ or _____
Inhaler/Glucometer/Epi-pen Name of Medication

We request that the above named student be permitted to carry the medication/medical device on his/her person or keep the medication in his/her backpack and/or locker. We consider the student to be responsible and he/she has been instructed in the purpose, appropriate method and frequency of use of the above medication/medical device.

My child understands the risks of carrying this inhaler/glucometer/Epi-pen or other medication and will not allow another student to use the above medication/medical devices.

We absolve Cherry Hills Christian of any responsibility in safeguarding our child's medication/medical device. If our child demonstrates irresponsible behavior with this medication or medical device, we understand our child's permission to carry it will be revoked by the nurse and/or principal.

If you **do not** want to provide duplicate medication to be kept in the CHC clinic please check this box. If you chose this option, you waive CHC of any liability in any delay of treatment for your child due to medications not being available in the clinic.

If you **do** want to provide duplicate medication to be kept in the CHC clinic please check this box.

Physician Signature

Date

Parent/Guardian Signature

Date

Parent/Guardian Signature

Both parents must sign

Date

Student Signature

Date

School Nurse Signature

Date

This form must be completed in addition to the Care Plan for a student to carry prescription medications while at school.



End of Year Medications
2018-2019 School Year

Student

Classroom

Cherry Hills Christian School is released from all liability and may send my child's medication home with him/her at the end of the school year. We accept full responsibility for the transportation and security of my child's medication from school to home.

I understand that the medication will be placed in my child's backpack on the last day of school.

Any medications remaining in the clinic at the end of the school year will be discarded July 1st.

Parent

Date