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

To be completed by healthcare provider

◊ 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

→

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 epinphrine. **USE EPINEPHRINE**

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

→

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: ______________

Student Name: ______________________ DOB: ______________________

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

1.______________________ Room ______________

2.______________________ Room ______________

3.______________________ Room ______________

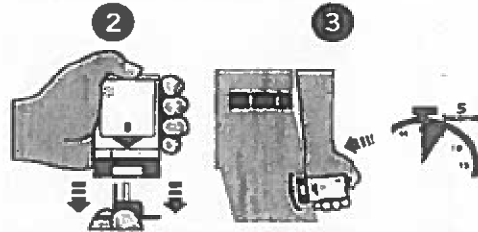
Self-carry contract on file: ☐Yes ☐No

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.

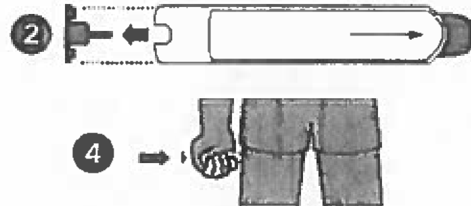


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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 disabilitiy if required by district policy.

Additional information: ____

____

____

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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: ☐ Albuterol ☐ Other: ____________ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: ______________________
	IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms	• 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: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms	• 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: ☐ 2 puffs ☐ 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: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

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