

STUDENTS WITH FOOD AND MILK ALLERGIES

In order to keep your child safe, we need the following:

Food Allergies:

A signed doctor's statement to include the following:

- (a) The food or foods to be omitted from the child's diet and the food or choice of foods that must be substituted.
- (b) Instructions for the school to follow if the child experiences an allergic reaction while at school. You may choose to use the attached emergency action form.
- (c) If your child is prescribed Epinephrine, we would prefer it to be in the form of an EpiPen or Auvi-Q.
- (d) Also, the attached medication forms must be completed and returned.

Your speedy attention to the above matter is appreciated. If you would like an opportunity to discuss your child's allergy and how we can implement a personalized health management plan, the principal will arrange a meeting with you and the school nurse.

Dear Doctor,

The parent has reported that this child has a food allergy. Please complete the following forms, so we can make appropriate arrangements for care.

Student's Name: _____ D.O.B: _____

ALLERGY TO: _____

is there a recommended food to substitute? _____

Asthmatic Yes* No

*Higher risk for severe reaction

TREATMENT ..

Symptoms:

Give Circled Medication

If a food allergen has been ingested, but no symptoms: Epinephrine .. Antihistamine

Mouth Itching, tingling, or swelling of lips, tongue, mouth Epinephrine .. Antihistamine

Skin Hives, itchy rash, swelling of the face or extremities Epinephrine .. Antihistamine

Gut Nausea, abdominal cramps, vomiting, diarrhea Epinephrine .. Antihistamine

Throat† Tightening of throat, hoarseness, hacking cough Epinephrine .. Antihistamine

Lung† Shortness of breath, repetitive coughing, wheezing Epinephrine .. Antihistamine

Heart† Weak or thready pulse, low blood pressure,

fainting, pale, blueness

Epinephrine .. Antihistamine

Other† _____

Epinephrine .. Antihistamine

If reaction is progressing

(several of the above areas affected), give:

Epinephrine .. Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Auvi-Q

Antihistamine:

give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

***PHYSICIAN'S SIGNATURE

Date

PARENT/GUARDIAN SIGNATURE

Physician's signature required for allergy requiring medication

Barberton City Schools
Medication Administration Record (MAR)
(Including Asthma Inhaler and Epinephrine Autoinjector Use)
Student Information

Student Name			Date of Birth		
Student Address					
School		Grade	Teacher		School Year
List my known drug allergies/reactions			Height	Weight	

Prescriber Authorization

Name of Medication		Circumstance for use		
Dosage		Route	Time Interval	
Date to begin medication		Date to end medication		
Circumstances for use				
Special instructions				
Treatment in the event of an adverse reaction				
Epinephrine Autoinjector:		<input type="checkbox"/> Epipen in locked cabinet in office <input type="checkbox"/> Self Carry, Yes as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler:		<input type="checkbox"/> Inhaler in locked cabinet in office <input type="checkbox"/> Self Carry, Yes, if conditions are satisfied per ORC 3317716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication if it does not produce the expected relief				
Possible Severe Adverse Reaction(s) per ORC 3317716 and 3313718				
a) to the student for whom it is prescribed (that should be reported to the prescriber)				
b) to a student for whom it is not prescribed who received a dose				
Other medication instructions				
Does medication require refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prescriber signature		Date	Phone	Fax
Prescriber name (print)				
Reminder note for prescriber ORC 3313718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler				

Parent/Guardian Authorization

- I authorize an employee of the board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.
- Medication form must be received by the principal, his/her designee and/or the school nurse. I understand that the medication must be in the **original** container and be properly labeled with the student's name prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
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Parent/Guardian Self-Carry Authorization

- For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.
- For Asthma inhaler: as the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
Principal signature			Date