# Anthony Wayne Local Schools

Severe Food Allergy

Welcome to Anthony Wayne Schools! In preparation for the upcoming school year, the following forms need to be completed and returned before the first day of school.

All medications must be in the correctly labeled bottle with a date that is the current school year. Medication MAY NOT be sent to school with the student. They should be brought into school by the parent or guardian.

1. *Food Allergy Health History*
   Completed each school year by **Parent**

2. *Anaphylaxis (Severe Allergy) Action Plan and Medication for Anaphylaxis*
   Completed each school year and signed by **Physician** and **Parent**

If you choose not to have emergency medication available at school, please notify the nurse in your child's building.

Please call the school office if you have questions, we would be happy to help you.

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Fay Birkemeier, RN
Monclova Primary
419-865-9408

Valerie Bradfield, RN
Waterville Primary
419-878-2436

Laura Soeder, RN
Whitehouse Primary
419-877-0543

**ANTHONY WAYNE LOCAL SCHOOLS**

# Food Allergy Health History

## Student Information

| | |
|---|---|
| | School year |
| Student Name | Grade |
| Food Allergy | |
| Other Allergies | |
| Primary Healthcare Provider | Phone Number |
| Allergist | Phone Number |

## Reaction History

| | |
|---|---|
| How many times has your child experienced an allergic reaction to this food? | When was your child's most recent allergic reaction? |
| Describe your child's typical symptoms during an allergic reaction. | |
| How does your child communicate his/her symptoms (Include what your child may say). | |

## Treatment

| |
|---|
| How have past reactions been treated (include medications given). |
| How effective was student's response to treatment? |

## Medication at School

| | |
|---|---|
| I will provide the school with emergency medication (your physician will need to complete the appropriate Medication Administration Forms and Action Plan) | YES NO |
| My child will carry his medication, whether it be on his person or in his backpack (your physician will need to approve this on the appropriate Medication Administration Form) | YES NO |

## Students with Peanut/Nut Allergies

| | |
|---|---|
| My child will need to sit at the "Peanut/Nut-Free" table at lunch. Any child may sit at these designated tables as long as he or she is not eating food containing peanuts or nuts. | YES NO |
| My child's peanut/nut allergy is airborne.<br>(*)The classroom will be "peanut/nut-free", no peanuts or nuts in the classroom. | YES NO |
| My child may eat packaged food that does not contain peanuts/nuts, but is processed in a facility that uses peanuts/nuts. | YES NO |

## Parent/Guardian Authorization

| | |
|---|---|
| All School Health information is handled in a respectful and confidential manner. May the nurse share the above information with school staff on a "need to know" basis? | YES NO |
| May we share your child's food allergy with your child's classroom? We will not use your child's name, but will inform parents that a child with a food allergy is in the classroom, please refrain from sending in shared treats with this food ingredient. | YES NO |
| Parent/Guardian Signature | Date |

Please contact the school for any questions or concerns

# Individualized Health Care Plan - Severe Allergy

| Student Name |
| --- |
| Allergy |

**Any SEVERE SYMPTOMS**
**after suspected or known ingestion:**

**One or more** of the following:
LUNG: Short of breath, wheezing, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

**1. GIVE** _____

2. 911
3. Alert School Nurse and Parent
4. Begin monitoring (see box below)
5. Give additional medications as ordered:

_____

_____

**MILD SYMPTOMS ONLY:**
MOUTH: Itchy Mouth
SKIN: A few hives around mouth/face, itch
GUT: Mild nausea/discomfort

**1. GIVE** _____

2. Stay with student; alert School Nurse and Parent.
3. If symptoms progress (see RED box above)
4. Begin monitoring (see box below)

☐ **If checked, give epinephrine immediately even if NO SYMPTOMS and exposed to the allergen**

**Monitoring**: Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given: request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given five minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

## Foods to Avoid

specific to student

## Individual notes:

specific to student

## Symptoms experienced in the past:

specific to student

Parent Signature _____ Physician Signature _____

Date _____ Date _____

See Back for Physician Medication Order

**Anthony Wayne Local Schools**

***Medication for Anaphylaxis (Severe Allergy)***

## Student Information

| Student Name | | Date of birth |
|---|---|---|
| Address | | |
| Weight | **Asthma:** ☐ **YES (Higher risk for a severe reaction)** ☐ No | |
| Allergies: | | |

## Prescriber Authorization

| Epinephrine (brand and dose): | |
|---|---|
| Antihistamine (brand and dose): | |
| Other (e.g., inhaler-bronchodilator if asthmatic): | |
| Date to begin medication | Date to end medication |
| Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief | |
| Special Instructions | |
| **Authorization is hereby given for the student named above to (please ☑)** | |
| ☐ **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.** | |
| ☐ **Receive the prescribed medication indicated from the designated school personnel.** | |
| Prescriber signature | Date |
| Prescriber name | |
| Phone | Fax |

## Parent/Guardian Authorization

☑ I understand that according to Anthony Wayne Board of Education Policy 5330 (Use of Medication) this form must be completed by the prescribing physician and parent prior to administration of prescription medication by designated school personnel. ☑ I authorize a designated employee of the Anthony Wayne Board of Education to administer the above medication. ☑ I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. ☑ I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. ☑ 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. ☑ **I understand that Ohio law requires a "back-up" epinephrine autoinjector is available at the designated school health clinic or office for emergencies.** {ORC 3313.718(3)}

| **Parent must ☑ below to indicate student is allowed to self-carry their epinephrine autoinjector** | |
|---|---|
| ☐ **I authorize self-medication by my child for the prescribed listed medication.** | |
| ☐ **I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician.** | |
| Parent/Guardian Signature | Date |
| #1 Contact phone | #2 Contact phone |

| **School Personnel Only** | Location #1 | Location #2 | Expiration | School Nurse/School personnel signature |
|---|---|---|---|---|
| Epinephrine | | | | |
| Antihistamine | | | | |
| Inhaler | | | | Date |