Westerville City Schools

936 Eastwind Dr., Westerville, OH 43081
Main Office (614) 797-5700 Fax (614) 797-5701

Vision

Our vision is to be the benchmark of educational excellence.

Mission

Our mission is to prepare students to contribute to the competitive and changing world in which we live.

Values

Respect
Inclusiveness
Community
Communication
Collaboration
Innovation
Nurturing
Trust
Accountability

Dear Parent/Guardian,

According to our health records, your student has a history of **Severe Allergies**. If your child requires medication to be available to them while at school for allergy treatment, please complete the following:

1. **Allergy Action Plan** (may be substituted with medical provider's form if all information included) - Must be completed and signed by medical provider AND parent/guardian.

2. **Authorization for Student Possession and Use of an Epinephrine Auto-injector** - Medical provider and parent must complete and sign if you would like your student to carry their epinephrine auto-injector with them during school hours. Please note: If you choose the self-carry option for your child, you must provide an additional Epinephrine Auto-Injector to be kept in the clinic.

3. **Request to Administer Prescribed Medication to a Student During School Hours** - All over the counter medication kept in the clinic must have a provider's signed order on file. If your student requires medication in addition to Epinephrine, such as an antihistamine (i.e. Benadryl, Zyrtec), please request your medical provider complete and sign this form. A parent/guardian must also sign this form.

4. **Cafeteria Diet Modification Form** - If your child will need a special diet such as food substitutes from the cafeteria, please ask your medical provider to complete and sign this form. A parent/guardian must also sign this form.

If you would like a copy of the *Westerville City Schools Resource Guide for Supporting Children with Life-Threatening Allergies*, please let your school nurse know. It can also be found on the school district's website under Health Services.

Please contact the school health clinic with any questions or concerns.

Sincerely,

Westerville City School District School Nurses

Revised August 2022

Westerville City Schools Allergy Action Plan

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

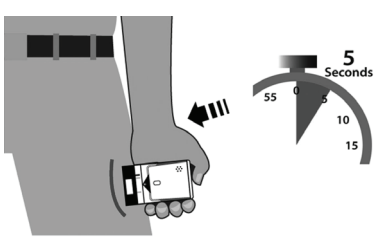
HSS 5335 F4b (2 sided) 4-4-2017 FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 3/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

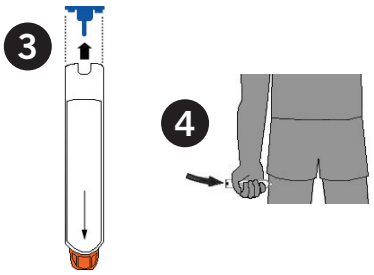
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



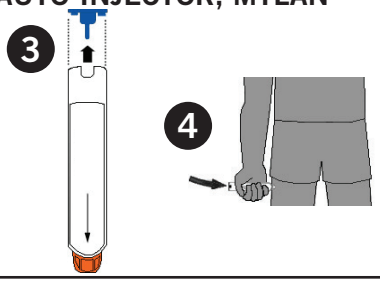
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



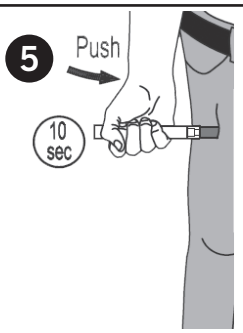
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 3/2017

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

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.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

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.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

CAFETERIA – COMPLETE ONLY IF YOUR CHILD NEEDS DIET MODIFICATION IN CAFETERIA

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name_____ Student Name_____
School Name_____ Date of Birth_____

STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY MUST HAVE THIS SECTION COMPLETED BY A PHYSICIAN

PHYSICIAN'S STATEMENT Date _____

I declare the child listed above to possess a LIFE THREATENING FOOD ALLERGY. _____
Physician's Name (please PRINT)

1. Life threatening food allergy – Circle all foods that must be omitted:

milk peanuts tree nuts eggs fish shellfish wheat soy gluten other
life threatening food allergy, specify _____

2. Can the student consume foods where the allergen is an ingredient in the food product? ____ yes ____ no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Explain:

3. Foods to Substitute ***(NOTE: WCS cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or physician refers patient to registered dietitian who specifies menu items.)***

_____ _____
Physician's Signature Date

_____ _____
Telephone Clinic/Facility and Address

_____ _____
Parent's Signature Telephone

Additional Notes:

WESTERVILLE CITY SCHOOLS

REQUEST TO ADMINISTER PRESCRIBED MEDICATION TO A STUDENT DURING SCHOOL HOURS
As Required By Section 3313.713 Ohio Revised Code

Student Name: Date of Birth:

Student Address:

School: Grade: Teacher:

PARENT SECTION

1. This form must be completed by both the parent (top section) and the prescriber (bottom section)
2. Medication must be kept in the **student's prescription labeled bottle**. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instructions from prescriber. If it is a non-prescription drug, it must be in the original container.
3. Deliver no more than 2 -4 weeks supply of medication to school clinic staff directly by the parent/guardian or other responsible adult at parental request. This should be arranged in advance.
4. A revised statement signed by the prescriber must be provided for any changes. A new form is required every school year.

When possible, give medication outside of school hours. *CONSENT : I, give consent for School Staff to make direct contact with the prescriber should an emergency adverse reaction indicated below occur. This consent does not supersede nor abrogate the "Emergency Medical Form".

Signature of parent:_____ Date: _____
Parental signature authorizes school personnel to administer the below prescribed medication.

Parent phone number: _____ _____
Day time Evening

PHYSICIAN SECTION

I verify that this medication must be taken by: _____
Name of Student

FOR DAILY MEDICATIONS (When possible, please attempt to schedule medication outside of school hours)

DRUG	DOSE	ROUTE	TIME TO BE GIVEN

FOR AS NEEDED MEDICATION

DRUG	DOSE	ROUTE	TIME INTERVAL BETWEEN DOSES

Diagnosis for which medication is prescribed?	
Any severe adverse reactions that should be reported to the prescriber *?	
Special instructions for administration, including sterile conditions and storage?	
Start date to administer at school:	Expiration date:

X
Prescriber's Signature **Date**

Prescriber's Printed Name: Phone:

Prescriber's Address:

If faxed to school, it is the parent's responsibility to ensure it is received **FAX NUMBER:** _____