MIDVIEW LOCAL SCHOOL DISTRICT
ALLERGY ACTION PLAN

Dear Parent or Guardian,

Your child's school health records indicate that they have an allergy. In order for us to care for your child during an allergic reaction at school we need to have an Allergy Action Plan completed. Please have your physician complete and sign the attached Allergy Action Plan for your child and return it to the school with any emergency allergy medication that may be needed. If your child does not require any emergency allergy medication at the school this year then please complete the bottom portion of this letter and return it to school as soon as possible. Please feel free to call me with any concerns or questions you may have at 748-5302.

All paper work and medication must be must be in place prior to the start of the school year.

Thank you,

Michelle Moran, RN
District Nurse - Midview Local Schools
Lorain County Public Health
Office phone: 440-748-5302 Cell phone: 440-371-5406
mmoran@midviewk12.org mmoran@lorainchd.com
Lorain County Public Health

Please complete this portion if your child does not require any emergency allergy medication administration for their allergy.

Name of student _____ Grade_____

Allergic to _____

Type of reaction that occurs _____

_____

If my child has a reaction I would like the school to _____

_____

My child no longer requires any intervention for the above allergy _____

Parent signature _____ Date _____

Phone number _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE 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
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/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/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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): _____

_____

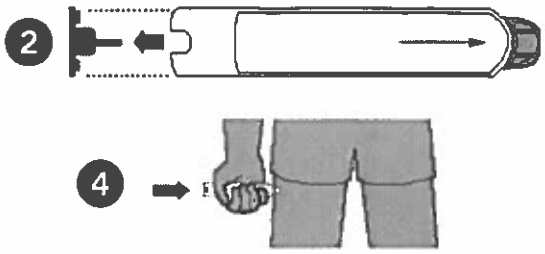
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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.



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.

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) 7/2016

Midview Local School District
Medication Administration Process

In order for your child to take medication during the school day the following steps must be completed:

1. A Medication Authorization Form is required for any and all medication that is to be given at school. This includes both **prescription medication** as well as **over the counter medication**.
2. The Medication Authorization Form must be completed and signed by a physician and a parent.
3. All medication must be brought in to the school by an adult. No child shall carry medication to or from school, unless it is an inhaler or an Epi pen and the proper paperwork is in place prior to them having it.
4. No medication will be sent home with a child on the bus.
5. All medication must be in the original container and clearly labeled with the student's name.
6. All prescription medication must be in the original container with a current medication label. The label must contain the student's name, the drug name and dosage, and the correct dosing information.
7. Parents are responsible for cutting any pills that require being split.
8. Parents are responsible for providing any medication measuring spoons or cups for a medication.
9. The school does not supply any medications to the students (Acetaminophen, cough drops, eye drops, ointments, etc.)
10. **No medication will be accepted at the school prior to the paperwork being completed and on file.**

For questions regarding Medication Authorization and Administration please contact Michelle Moran R.N., Midview School Nurse, at 440-748-5302 or mmoran@midviewk12.org.

MIDVIEW LOCAL SCHOOLS 5330 F1
AUTHORIZATION OF MEDICATION REQUEST

This form must be completed by both the physician who prescribes the medication and the parent or guardian prior to the school personnel being permitted to administer medication.

PHYSICIAN'S AUTHORIZATION (All items MUST be completed)

Student's Name: _____, Age_____ Physician's Name (print)_____

School: _____ Grade: _____ Physician's Signature_____

Parent/Guardian's Name _____ Emergency Telephone: (__) _____

Address: _____ Address: _____

_____ Physician's Telephone: (__) _____

Parents/Guardian Telephone: (__) _____

Emergency Telephone: (__) _____

This child is under my care for _____ and should receive
(CONDITION)

_____ in the following dosage _____, at the following
(EXACT NAME OF DRUG) (EXACT DOSAGE)

time(s) _____ beginning on _____ and ending on _____.
(EXACT HOURS) (DATE) (DATE)

This medication may cause the following adverse reaction which should be reported to the physician immediately: _____

_____

This medication requires the following special storage or stile conditions (note: the school will provide storage for drugs needing refrigeration):_____

_____

PARENT/GUARDIAN AUTHORIZATION AND CONSENT

I, _____, _____, (___)_____
(Parent/ Guardian Name) (Address) (Phone No)
hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer medication prescribed and directed by the physician, the following medication: _____ to my child.

I also agree to comply with a the Ohio Law which requires me to deliver the medication to the school in its original container and to comply with the guidelines of the School Board Policy which require me to receive the medication at is expiration date or the end of the school year, whichever occurs first and any other procedures which the Board may establish.

I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

_____ _____
(Signature of Parent/Guardian) (Date)

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.