

**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 in place prior to the start of the school year.

Thank you,
JoAnne Ferritto, R.N.
Midview School Nurse

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 _____

Allergy Action Plan

Midview Local School District

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



Allergy to: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:	Give Checked Medication**
	**(To be determined by physician authorizing treatment)
<input type="checkbox"/> Child has been exposed to allergen, but no symptoms	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Throat♥ Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Lung♥ Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Heart♥ Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Other♥ _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> 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
 (see reverse side for instructions) EpiPen located _____

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

Doctor's Signature _____ Date _____
Required

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

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent _____ Phone Number(s) _____

4. Emergency contacts:
 Name/relationship Phone Number(s)

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

I hereby give my consent to any employee of the Midview School Board, who has been duly authorized by the Board, to administer, to my child, the medications as prescribed above by their physician. I also, agree to deliver the medication to the school in it's original container clearly labeled with my child's name.

Parent/Guardian's Signature _____ 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 <i>not</i> 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.