"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS

Request for Additional Information Concerning Food Allergy

Dear Parent/Guardian:

If your child has a **life-threatening** food allergy requiring emergency medication (i.e.: Epinephrine Auto-injector and/or Benadryl), please forward the following items to the school:

- A current small picture of your child until we are able to photograph him or her. The picture will be placed on his or her Emergency Allergy Plan so that staff can recognize and identify your child.

- A signed Emergency Allergy Plan (attached) from both you and your child's physician with instructions the school is to follow in the event of an allergic reaction in school.

- Two Epinephrine pens (EpiPen), if prescribed and/or other medication such as Benadryl to be used if an allergic reaction occurs. Students are permitted to carry their own emergency medication if authorized by the physician, parent/guardian, and the school. ***Children who carry their own emergency medication MUST have the appropriate documents on file in the school clinic. AND back up dose on file in clinic.** (For those students who are not permitted to carry the medication, it will be located in the clinic and readily available should the need occur).

If your child's allergy is NOT life-threatening and does NOT require emergency medication, please complete and return the Notification of Non-Emergent Food Allergy form (attached) with a physician's signature. (A physician's note declaring the medical/dietary needs, food(s) to be omitted, and food(s) to be used as substitutions will also be accepted). Please remember, food services will NOT be notified until this information is received. Therefore, your child will not receive any food substitutions should they attempt to purchase lunch until the District receives the physician information.

Your prompt attention to this matter is greatly appreciated. If you should have any questions or would like to meet to discuss your child's allergy, please feel free to call me.

Sincerely,

Carolyn Baetjer RN

Carolyn Baetjer, R.N., BSN, NCSN
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"We Inspire and Empower Learners"

NSG-200F
Rev. 01-2016

NORTH ROYALTON CITY SCHOOLS
EMERGENCY ALLERGY PLAN
* CONFIDENTIAL*

☐ Addendum Attached

_____ _____
Received by Date

This form is intended to be used as an addendum to a Section 504 plan, if necessary, or for those students who need allergy-related support in the school environment but are not eligible under Section 504. Use of this form for 504-eligible students does not eliminate the need for a 504 plan (DSE-504D).

Student's Name	Student's Date of Birth	Grade
Allergy to:		School Year

Asthmatic: YES* ☐ or NO ☐ (Please check one) *Higher risk for severe reaction

Child's Picture

STEP 1: TREATMENT (To be completed by physician)

SYMPTOMS:	GIVE CIRCLED MEDICATION: (TO BE DETERMINED BY PHYSICIAN)	
If a food allergen has been ingested, but **NO SYMPTOMS**:	Epinephrine	Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue	Epinephrine	Antihistamine
Skin: Hives, rash, swelling of face or extremities	Epinephrine	Antihistamine
Gut: Nausea, cramping, vomiting, diarrhea	Epinephrine	Antihistamine
Throat*: Tightening of throat, hoarseness, cough	Epinephrine	Antihistamine
Lung*: Shortness of breath, coughing, wheezing	Epinephrine	Antihistamine
Heart*: Thready pulse, low blood pressure, fainting	Epinephrine	Antihistamine
Other:	Epinephrine	Antihistamine
If reaction is progressing or several of the above areas are affected, give:	Epinephrine	Antihistamine

Potentially life-threatening. 911 WILL BE CALLED IF EPIPEN IS ADMINISTERED

Inject Epinepherine Intramuscularly: (indicate dosage)

- ☐ **Epinepherine Autoinjector 0.3 mg**
- ☐ **Epinepherine Autoinjector 0.15 mg**

Antihistamine:_____
(Name/Dose/Route)

List any accommodations required:

STEP 2: EMERGENCY CALLS

1. Call 911 and state that an allergic reaction has been treated with:_____
(Name of Drug)

2. Call Parent/Guardians:

Name/Relationship	Phone Number(s)	
a.	1.	2.
b.	1.	2.

3. Notify Dr._____ **at** _____
(Name) **(Phone Number)**

I GIVE PERMISSION FOR SCHOOL PERSONNEL TO FOLLOW THIS PLAN, ADMINISTER MEDICATION (IF ANY) AND CARE FOR MY CHILD AND CONTACT MY PHYSICIAN IF NECESSARY. I ASSUME FULL RESPONSIBILITY FOR PROVIDING THE SCHOOL WITH PRESCRIBED MEDICATION AND DELIVERY/MONITORING DEVICES. I APPROVE THIS EMERGENCY ALLERGY PLAN FOR MY CHILD. I ALSO CONSENT TO THE RELEASE OF THE INFORMATION CONTAINED IN THIS PLAN TO ALL STAFF MEMBERS AND OTHER ADULTS WHO HAVE CUSTODIAL CARE OF MY CHILD AND WHO MAY NEED TO KNOW THIS INFORMATION TO MAINTAIN MY CHILD'S HEALTH AND SAFETY.

Parent/Guardian(s) Signature	Date
Physician's Signature	**Date**

********AUTHORIZATION FOR STUDENT POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR***********

To be completed ONLY if student will be carrying Epinephrine Autoinjector

(In accordance with ORC 3313.718/8313.141)

This form must be completed in its entirety. The administration of prescription medication requires a physician's and parent/guardian permission.

Student Name
Student Address

This section must be completed and signed by parent or guardian: As parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at school and any activity, event, or program sponsored by or in which the student's school is a participant. I agree to comply with Board policy and regulations regarding self-administration of medication. I also agree to submit a revised authorization if any of the information contained in this document should change. I understand that pursuant of Ohio Revised Code, Section 3316.716, the Board and its employees are not liable for my child's self-administration of this medication. 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 back-up dose of the medication to the school as required by law.

Parent/Guardian Signature	Date
Parent/Guardian printed name	Parent/Guardian emergency phone number ( )

This section must be completed and signed by medication prescriber/health care provider:

Name of medication	Dosage of medication
Start date:	End date:
Circumstances for use of epinephrine autoinjector:	
Procedure for school staff to follow if student is unable to administer this medication or if it does not produce the expected relief:_____ _____ _____	
Possible severe adverse reactions to student for which it is prescribed:	
Possible severe adverse reactions to UNAUTHORIZED user:	
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 ( )