STUDENTS WITH FOOD AND MILK ALLERGIES

In order to keep your child safe, we need the following:

FOOD ALLERGIES:

1. Two or more small pictures of the student, which will be displayed in the cafeteria and other appropriate places in the building.(We can take and print these, if you don't have extras).
2. A signed doctor's statement to include the following:
    (a) The food or foods to be omitted from the child's diet and the food or choice of foods that must be substituted.
    (b) Instructions for the school to follow if the child experiences an allergic reaction while at school. You may choose to use the attached emergency action form.
    (c) If your child is prescribed Epinephrine, we would prefer it to be in the form of an Epipen or Auvi-Q.
    (d) Also, the attached medication forms must be completed and returned.

Your speedy attention to the above matter is appreciated. If you would like an opportunity to discuss your child's allergy and how we can implement a personalized health management plan, the principal will arrange a meeting with you and the school nurse.

MILK ALLERGY:

School authorities are required to obtain documentation of the type of milk sensitivity. Please have your doctor complete the section below and return to your child's school. Please note that schools are no longer permitted to substitute juice or water in place of milk, unless specified by your doctor for a ***life threatening*** allergy.

FORMS BELOW

PHYSICIANS FORM FOR MILK ALLERGY

_______________________________ _________________________________

CHILD'S NAME *DATE OF BIRTH*

☐ LIFE THREATENING **MILK ALLERGY**

BEVERAGE TO BE SUBSTITUTED ________________________________

☐ NON LIFE THREATENING **MILK SENSITIVITY**

CHOOSE ONE

☐ SCHOOL WILL PROVIDE LACTOSE FREE MILK

☐ PARENT WILL PROVIDE BEVERAGE OF CHOICE

__________________________________ ____

****PHYSICIAN'S SIGNATURE* *PARENT/GUARDIAN SIGNATURE*

Physician's signature required for life-threatening milk allergy

Dear Doctor,
The parent has reported that this child has a food allergy. Please complete the following forms, so we can make appropriate arrangements for care.

Student's Name:________________________________D.O.B:_____________
ALLERGY TO:_______________________________
is there a recommended food to substitute?_________________________________

Asthmatic Yes* No *Higher risk for severe reaction

TREATMENT ..

Symptoms:	**Give Circled Medication**
If a food allergen has been ingested, but no symptoms:	Epinephrine .. Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine .. Antihistamine
Skin Hives, itchy rash, swelling of the face or extremities	Epinephrine .. Antihistamine
Gut Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine .. Antihistamine
Throat† Tightening of throat, hoarseness, hacking cough	Epinephrine .. Antihistamine
Lung† Shortness of breath, repetitive coughing, wheezing	Epinephrine .. Antihistamine
Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine .. Antihistamine
Other† ______________________________________	Epinephrine .. Antihistamine
If reaction is progressing (several of the above areas affected), give:	Epinephrine .. 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 Auvi-Q

Antihistamine:
give____
medication/dose/route

Other: give____
medication/dose/route

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

_______________________________ _______________________
****PHYSICIAN'S SIGNATURE* Date

____
PARENT/GUARDIAN SIGNATURE

Physician's signature required for allergy requiring medication

Barberton City Schools
Medication Administration Record (MAR)
(Including Asthma Inhaler and Epinephrine Autoinjector Use)
Student Information

Student Name				Date of Birth
Student Address				
School	Grade	Teacher		School Year
List my known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of Medication	Circumstance for use	
Dosage	Route	Time Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector:	☐ Epipen in locked cabinet in office ☐ Self Carry, Yes 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.	
Asthma Inhaler:	☐ Inhaler in locked cabinet in office ☐ Self Carry, Yes, if conditions are satisfied per ORC 3317716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.	
Procedures for school employees if the student is unable to administer the medication if it does not produce the expected relief		
Possible Severe Adverse Reaction(s) per ORC 3317716 and 3313718 a) to the student for whom it is prescribed (that should be reported to the prescriber)		
b) to a student for whom it is not prescribed who received a dose		

Other medication instructions Does medication require refrigeration? ☐ Yes ☐ No			Is the medication a controlled substance? ☐ Yes ☐ No
Prescriber signature	Date	Phone	Fax
Prescriber name (print) Reminder note for prescriber ORC 3313718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler			

Parent/Guardian Authorization

☐ I authorize an employee of the board to administer the above medication. ☐ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ↑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☐ Medication form must be received by the principal, his/her designee and/or the school nurse. ↑ 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 when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

☐ For Epinephrine Autoinjector: 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.

☐ For Asthma inhaler: as the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
Principal signature			Date