Allergy Form

Please complete this packet and return to your school at your earliest convenience

What's in this packet?

1) An Allergy Questionnaire to describe student's allergies

2) Release of Information allows the doctor to talk to the school nurse if there are any questions

3) In case the student uses an Epi-pen or similar medicine: Guidelines for Medicines at School Medication Authorization must be signed by parent and doctor and brought to school with the medication (for medications like Benadryl.) Epinephrine Auto-injector Medication Authorization must be signed by the doctor and brought to school with the medication (for medications like Epipen.)

4) Special Diet Order for parent and doctor to sign in case the student has a food allergy that requires a special diet.

Questions? Please contact your school nurse jaime.mckeiver@cvcsd.com . New, enrolling students, please contact: Central Office, Circleville City Schools Enrollment (740) 474-4340.

Allergy Questionnaire
Completed by parent/guardian

Student Name_____
D.O.B._____ School Year_____
Homeroom/Grade_____

Current information indicates that this child has a history of allergies. To provide care while this child is at school, please complete the information below so the school nurse has a better understanding of the allergies.

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider?

☐ Yes ☐ No

Please list all of the child's allergies, including foods:

Does this child react to skin contact with the allergen? ☐ Yes ☐ No
If so, what is the reaction?

Does this child react to swallowing the allergen? ☐ Yes ☐ No
If so, what is the reaction?

How soon after exposure does this child react?

How does this child prevent and respond to an allergic reaction? (check all that apply)

___ *The child knows what to avoid*
___ *The child asks about ingredients in food, if unsure*
___ *The child tells others about his/her allergies*
___ *The child will immediately tell an adult if exposed to an allergen*
___ *The child can give their own injection with an Epipen if prescribed by their healthcare provider*

*Other*_____

What medical care was given in the past? (fill out all that apply)

____*Cold compress (in cases of a sting)*_____
____*Oral medication: What was used?* _____
____*Injection: What was used?* _____
____*Treatment in doctor's office* _____
____*Treatment in the Emergency Room or your child was in the hospital?*_____
*Other:*_____

Does this child wear an identifying tag or bracelet alerting others to the allergy? ☐ Yes ☐ No

Are medications required to be kept at school? ☐ Yes ☐ No
If yes, what kind?

_____
_____
_____
_____
(All medications at school require a signed Medication Authorization to be on file at school)

Additional Info?

_____
_____
_____
_____

Parent Signature_____ ***Date***_____

Primary Contact Number_____

Epinephrine Auto-Injector Medication Authorization

*Student name*_____ *D.O.B.*_____

*Home address*_____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs or symptoms _____

Medication_____ Dosage_____ Route_____

Beginning Date _____ Expiration Date_____ or end of school year

CALL 911 when medication is administered. Repeat dose if medication does not produce relief ☐yes ☐no

Other medications prescribed to this student (home & school) _____

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY:

I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ yes ☐ no

The student is capable of possessing and self-administering the auto-injector per ORC 3317.716 and 3313.718. ☐ yes ☐ no

Per state law, I prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. ☐yes ☐no

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

*School*_____ *School Year*_____

*Homeroom/Grade:*_____

Parent to Complete:

*Parent/Guardian Name*_____ *Phone Numbers* _____ *or* _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- Both the parent and healthcare provider portions of this form must be completed.
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability and will have the assistance of trained staff as needed.
- I understand emergency medical service will be called if the epinephrine auto-injector is used. I understand the medication
- If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events **(circle) : yes no.**
- I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911. I agree to provide the school with backup dose of epinephrine as required by law.

- I understand emergency medical service will be called if the epinephrine auto-injector is used. I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Circleville City Schools staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization

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Parent/Guardian Signature_____ **Date**_____

Special Diet Order

Federal regulations require diet orders to be submitted by October 1st of each school year or when orders change.

Please provide the following special diet instructions for:

Student Name_____ Date of Birth_____ School Year_____

School_____ HR / Grade_____ Preschoolers Only: ☐ Morning session ☐ Afternoon session

Parent/Guardian Signature_____ Date_____

Healthcare Provider to Complete:

Diagnosis/Allergen:

Diet order: Please specify restricted foods if indicated.

PLEASE NOTE – for students with severe nut allergy, Circleville City Schools purchases foods from manufacturers that may share equipment, and may use the same facilities that process nuts. Advise parents and school accordingly if the above student with severe nut allergies will need to pack their breakfast and lunch.