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@cvcisd.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__________________________________
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.

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.