DAYTON
PUBLIC SCHOOLS

Health Services Department
937-542-3346

Health Forms for Students with Allergies (Including Food Allergies)

Please complete packet and return to your child's school nurse.

What is in this packet?

1) **STUDENT ALLERGY HISTORY FORM** – for parent to describe student's allergy history and list current medications.

2) **MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM**

- Guidelines for Medications at School – On Page 2 of Medication Authorization Form
- This form includes a section for epinephrine auto-injector orders including self-carry option if ordered by your child's Health Care Provider (HCP)
- Most oral allergy medications can be given at home before or after school, but if an oral asthma medication must be given at school, please complete this form
- Must be signed by parent and Health Care Provider (HCP)
- Signed form and medication should be brought to school by a responsible adult
- Both the parent (in Parent/Guardian Authorization section) and HCP (in Prescriber authorization section) need to check the box for self-carry if inhaler is not kept in the clinic

3) **ALLERGY ACTION PLAN**

- Your Health Care Provider's Allergy Action Plan form works (but Medication Authorization Form / General Medication Form is also needed) or you may use the **SCHOOL ALLERGY ACTION PLAN** included. This form combines the ALLERGY ACTION PLAN with the Medication Authorization form so you won't need form #2 above.

If your child already has a current Allergy Action Plan, please bring it in for the school nurse to copy. If not, please ask for one at your child's next appointment.

4) **SPECIAL DIET ORDER FORM – FOR NUTRITIONAL SERVICES** - Please have this form completed and signed by your Health Care Provider and turn in to the school nurse each school year. Your school nurse will email/fax the form to nutrition services and keep a copy for your child's health records.

5) **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Questions? - Please call your school nurse

STUDENT ALLERGY HISTORY

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Parents: Please complete information below so your school nurse can provide care and create an Emergency Action Plan for your child, if needed. Please return this form to your school nurse.

CONTACT INFORMATION:

Student's Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Homeroom: _____
Parent/Guardian Name: _____ Email: _____
Parent Guardian Tel: (H) _____ (W) _____ (C) _____
Allergy Physician: _____ Tel: _____
Primary Care Doctor: _____ Tel: _____
Significant medical history or conditions: _____

ALLERGY INFORMATION:

1. **Has your child been diagnosed with allergies/anaphylactic reactions by a healthcare provider?**
   ❑No ❑Yes If yes, at what age or year? _____

2. **Please list all of your child's allergies, including foods:** _____

3. **Is it necessary to avoid physical contact or inhalation of allergen(s)?** ❑No ❑Yes

4. **How soon after exposure does your child react?** _____

5. **What are the early signs and symptoms of your student's allergic reaction?** *(Be specific; include things the student might say.)*

   _____

   _____

6. **List any symptoms your child has had in the past?**

   _____

7. **How responsible is your child in preventing and responding to an allergen(s)? (Check all that apply)**
   - ❑ My child knows what allergen(s)/foods to avoid
   - ❑ My child knows to ask about ingredients in food, if unsure
   - ❑My child knows to **immediately** tell an adult if exposed to an allergen
   - ❑My child knows to always have someone go with them for help if having an allergic reaction or after having administered their emergency medication
   - ❑My child can give their own injection with an epinephrine auto-injector (Epipen) if prescribed by their healthcare provider
   - ❑Other _____

8. **Does your child wear a medic alert?** ❑No ❑Yes

9. **Does your child require emergency medication at school?** ❑No ❑Yes
   If Yes, Indicate Medication Needed: ❑Epinephrine auto-injector ❑Benedryl ❑Other _____

Note: ☒A school Medication Authorization Form is required if any medication is given at school and must be completed/signed by a Health Care Provider (HCP) and parent.
☒New forms are required each school year.
☒For a student to "self-carry" their epinephrine auto-injector if prescribed by a HCP and a back-up epinephrine auto-injector must be kept in the clinic per ORC 3313.718.

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10. What medical care was given in the past? (Check and complete all that apply)

❑Oral medication prescribed: What oral med was used? _____

❑Injection prescribed: What was used? _____

❑Treatment in doctor's office _____

❑Treatment in the Emergency Room

❑ Kept in hospital as in-patient

❑Cold compress (in cases of a sting) and ❑Removal of insect stinger

❑Other _____

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary and to aid in present and future educational decisions.

Parent Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

❑ Original in student medical folder

❑ Copy in medication book if medications given at school

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DAYTON PUBLIC SCHOOLS

Medication Authorization Form
General Medication Form
(Includes Asthma Inhaler and Epinephrine Auto-Injector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	Schoolyear
School Nurse		Phone:	Fax:

Prescriber Authorization

Name of medication	Diagnosis	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	

Special instructions

Treatment in the event of an adverse reaction

Epinephrine Autoinjector (self-carry) ☐ Not applicable
☐ 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 (self-carry) ☐ Not applicable
☐ Yes, if conditions are satisfied per ORC 3317.716, 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 or if it does not produce the expected relief:

Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718
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 receives a dose

List any known drug allergies and reaction.

Prescriber's signature	Date	Phone	Fax
Prescriber name (print)			

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

Parent/Guardian Authorization

☑ I authorize an employee of the school 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 school nurse for the _____ school year to confer with the licensed prescriber regarding my child's health and treatment issues as they pertain to the medication/diagnosis and his/her attendance, educational, and behavioral management.

☑ 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 Auto-injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, 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

Received by (school nurse): _____ Date: _____

Adapted from Ohio Department of Health: Revised May 2016, Reviewed Feb 2020

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Guidelines for Medications at School

- DPS has one Medication Authorization form for all medications—oral, injectable, emergency (ex. Epinephrine Auto-Injector, asthma inhalers), and student self-carry medications.
- Any student needing to take medication during school hours **must have a Medication Authorization form** completed and signed by the parent and physician/prescribing healthcare provider.
- **All medication must be in the container in which it was dispensed** by the pharmacist or healthcare provider.
- The medication and Medication Authorization form must be brought together to the school by a parent or responsible adult.
- School personnel may not give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization form must be completed and signed.
- No new medication can be given until the school nurse has reviewed it and checked it in.
- Routine injectable medication can only be given by a school nurse, parent (or parent-designated adult), or self-administered by the student.
- Changes in medication must be provided by the healthcare provider.
- Routine daily medication ordered three times a day or less may not need to be taken at school. The medication should be given before school, after school and at bedtime unless it is time-specific for during the school day. **It is best for morning medication to be given at home.**
- All medication orders must be renewed each school year.
- Parents are notified in writing to pick up all remaining medications at the end of the school year. Per DPS policy, any unused medications not claimed by the last day of school each year will be destroyed.
- Parents will be required to pick up all medications with the exception of inhalers and Epinephrine Auto-Injectors that the student already has written permission from their primary healthcare provider to carry on him/herself.

Original: 2015; Revised: 2015, 2018, 2020

DAYTON PUBLIC SCHOOLS

Health Services Department
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DAYTON PUBLIC SCHOOLS FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____
Address: _____ School Building/Class: _____
Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.
☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG Shortness of breath, wheezing, repetitive cough

HEART Pale or bluish skin, faintness, weak pulse, dizziness

THROAT Tight or hoarse throat, trouble breathing or swallowing

MOUTH Significant swelling of the tongue or lips

SKIN Many hives over body, widespread redness

GUT Repetitive vomiting, severe diarrhea

OTHER Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - Antihistamine
  - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE Itchy or runny nose, sneezing

MOUTH Itchy mouth

SKIN A few hives, mild itch

GUT Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

ADAPTED FOR DPS MARCH 2020 FROM FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

DAYTON PUBLIC SCHOOLS

Health Services Department
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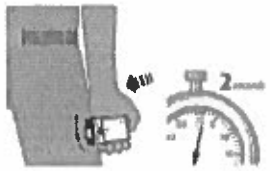
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

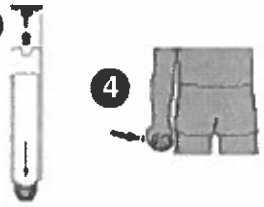
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



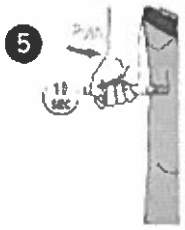
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



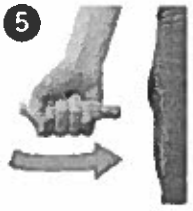
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

ADAPTED FOR DPS March 2020 from: FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

DAYTON PUBLIC SCHOOLS

Health Services
Return Form to Building School Nurse

SPECIAL DIET FORM – NUTRITION SERVICES

Please Return Form to Building School Nurse
(School Nurse Will Forward to Nutrition Services)

Student Name:_____ **DOB:** _____ **Year:** _____
School: _____ **Grade:** _____ **Home Room:** _____

PART A – Please complete this form if your child requires special meals. Current information must be submitted at the beginning of each school year

Does the child have a disability as defined in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990? If Yes, describe the major life activities affected by the disability.	**Yes** (Disability)	**No** (Disability)
Does the child have special nutritional or feeding needs? If Yes, have Health Care Provider complete and sign Part B.	**Yes** (Special Nutritional Needs)	**No** (Special Nutritional Needs)
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, please have your Health Care Provider complete and sign Part B.	**Yes** (Medical Reasons– No Disability)	**No** (Medical Reasons– No Disability)
If the child does not have a disability, does the child have special dietary needs? If Yes, please complete Part B and have it signed by the Parent/Legal Guardian.	**Yes** (Religious Reasons– No Disability)	**No** (Religious Reasons– No Disability)

PART B – TO BE COMPLETED BY A PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER

Please ☒ check mark any food allergies or intolerances child has and list the foods that are to be omitted & substituted.
Please make notation if it is a SEVERE/LIFE-THREATENING allergy. Note: Beverage substitutions may be limited due to regulations.

MILK ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Milk and uncooked dairy products only (Ex. Fluid milk, yogurt, cheese, etc.)
❑ Milk, dairy, and ALL milk products (includes cooked & denatured milk products. Ex. Breads, cookies, etc.)
❑ Fluid milk only
❑ Lactose Intolerant

Foods to be omitted: _____
Substitutions: _____

EGG ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Eggs only (Ex. Boiled, scrambled, individualized eggs
❑ Eggs and ALL egg products (This includes cooked and denatured egg products. Ex. Breads, muffins, etc.)

Foods to be omitted: _____
Substitutions: _____

NUT ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Peanuts
❑ Tree nuts
❑ Other

Foods to be omitted: _____
Substitutions: _____

SOY ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Soy only (Ex. Soy milk, soy yogurt, etc.)
❑ Soy and ALL soy products (This includes cooked and denatured soy products. Ex. Taco meat, chicken tenders, burger patty, etc.)

Foods to be omitted: _____
Substitutions: _____

OTHER ALLERGIES ❑ SEVERE/LIFE-THREATENING
Foods to be omitted: _____
Substitutions: _____

Do foods need to be modified in texture? If yes, please describe the modifications needed (i.e. chopped, finely ground, pureed, etc.):	**Yes** (Texture Modified)	**No** (Texture Modified)

Additional Dietary Restriction or Special Diet or Comments on child's eating/feeding concerns? Please describe.

Religious Restrictions (Does not need to be completed by a physician or medical authority) Please list foods restricted:

Parent/Guardian Signature	Best Daytime Phone	Date
Physician, or Medical Authority's Signature	Phone	Date

Please have Health Care Provider complete the Medication Authorization Form if medication(s) are ordered.

❑ ***Reviewed by school nurse & forwarded to Nutrition Services on*** _____ ***(date)*** _____ ***(School Nurse Signature)***

Revised March 2021

DAYTON PUBLIC SCHOOLS

Health Services Department
937-542-3346

DAYTON PUBLIC SCHOOLS

Authorization for Release of Student Medical Information

Dayton Public Schools

Patient Information

Last name	First name	Middle		
Address		City	State	Zip
Birthdate	Other possible names	Phone #		
School Attending:		Grade:	Home Room:	

Information Requested

☐	Immunization record	☐	Neurological
☐	General / Medical	☐	Surgical
☐	Counseling Record	☐	Orthopedic
☐	Emergency / Urgent care record	☐	Otorhinolaryngology (ENT)
☐	Other:	☐	Ophthamology

Action

☐ Mail Copies
☐ Fax copies

This information may be disclosed to and used by Dayton Public Schools. Mail to: School		The following individual or organization is authorized to make the disclosure:		
School Representative	Title			
Address		Address		
City	State / Zip	City	State	Zip
Phone#	Fax#	Phone#	Fax#	

Reason Needed

☐	Continuity of Medical Care	☐	Legal Reasons
☐	At request of the Individual	☐	Special Education
☐	School Related	☐	Other:

Authorization

I hearby authorize Dayton Public Schools (DPS) to release and/or receive medical information, to/from the above party. This authorization may include release of information concerning treatment of drug or alcohol abuse, drug related conditions, Human Immunodeficiency Virus (HIV) test results, diagnosis or AIDS related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this authorization shall remain in effect for the school year 20____ - 20____, unless an earlier expiration date is specified in this space (_____). I also understand that I may withdraw this authorization at anytime by written notification to the above parties involved. However, this written notification cannot effect actions that have taken place based on my prior authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Parent or Guardian	Date
Relationship to Student	
Signature of School Representative	Date

Health Services 2/2004; Rev March 2020