Centerville City Schools

EMERGENCY ALLERGY PLAN/EPINEPHRINE AUTHORIZATION

(In accordance with ORC 3313.718/3313.141)

Student Information

Student Name:	Birth Date:	Place Student Picture Here
Student Address:	Phone:	
School:	Grade/Teacher:	

Parent/Guardian Authorization *(All parents to complete)*

1. As the Parent / Guardian of this student: I authorize an employee of the school board to administer the prescribed medication at the school and any activity, event, or program sponsored by or in which the student's school is a participant.
2. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.
3. I also authorize Centerville City School's registered nurse to talk with the prescriber or pharmacist to clarify medication order.
4. I give permission for this information to be sent to the school via facsimile.
5. Medication can only be accepted by a Centerville City School's nurse **and** with the appropriately completed medication form.
6. I understand that the medication must be in the ***original*** container and be properly labeled with the student's name. If prescription, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration is required. ***Stock epinephrine auto injectors will not go on field trips.***

Parent/Guardian Name:	Phone #1:	Phone #2:
Parent/Guardian Signature:	Date:	

Parent/Guardian Self-Carry Authorization *(Only complete if student is going to self-carry)*

[1] As the Parent/Guardian of this student: **I authorize** my child to possess and self-administer 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, his/her designee, and/or Centerville City School's registered nurse as required by law.** (ORC 3313.718) ***Stock epinephrine auto injectors will not go on field trips.***
[2] As the Parent/Guardian of this student: I authorize my child to possess and self-administer antihistamine as needed for allergy plan. Medication must be in properly labeled containers and in the amount needed for this care plan.
[3] As the Parent/Guardian of this student: I understand that if epinephrine and/or antihistamine is self-administered, the student must notify the School Nurse or school employee.

Parent/Guardian Signature:	Date:

Special considerations and precautions for school activities, sports, field trips: Staff member in charge of the school sponsored event will be trained by the *school's registered nurse* in the administration of epinephrine auto injector. The medication will be provided to the staff member for safe storage *in locked medication bag* with precautions that the epinephrine auto injector will be kept at room temperature (59-86 degrees), out of extreme cold and heat, and kept out of direct sunlight. Staff members must have access to a phone. **Bus Precautions:** If anaphylaxis is suspected, the driver should pull over and call 9-1-1. If the student self-administers emergency medications the bus driver should pull over and call 9-1-1

*****MUST HAVE MEDICATION AUTHORIZATION FORM ON BACK COMPLETED BY PHYSICIAN *****

MEDICATION ORDERS

To be completed by physician

Student Name:	Birth Date:
ALLERGIC TO:	

[ ] If checked, give epinephrine immediately if student reports exposure (touch, smell, insect sting) to known allergen.

[ ] If checked, give epinephrine immediately if student reports ingestion of allergen.

9-1-1 will be called if epinephrine is administered, used auto injector will be given to EMS provider

FOR **ANY** *(1 or more)* OF THE **SEVERE** SYMPTOMS:

LUNG	**HEART**	**THROAT**	**MOUTH**
Short of breath, wheezing, repetitive cough	Pale, blue faint, weak pulse, dizzy	tight, hoarse, trouble breathing/ swallowing	Significant swelling of the tongue and/or lips

SKIN	**GUT**	**Other**	**Or a combination**
Many hives over body, widespread redness	Repetitive vomiting, severe diarrhea	Feeling something bad is about to happen, anxiety confusion	of symptoms from different body areas

1. INJECT EPINEPHRINE IMMEDIATELY
2. CALL 9-1-1

MILD SYMPTOMS

NOSE:	**MOUTH**:	**SKIN**	**GUT**
itchy/runny nose, sneezing	itchy mouth	a few hives, mild itch	mild nausea/ discomfort

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

FOR **MILD SYMPTOMS** FROM A **SINGLE SYSTEM** AREA:

1. Administer antihistamine as ordered
2. Stay with student and notify emergency contacts
3. Watch closely for changes. If symptoms worsen, give epinephrine.

EPINEPHRINE: inject intramuscularly

Circle one: 0.15mg 0.30 mg

Date to begin:_____ Date to end: _____

Adverse reactions for student prescribed_____

_____

Adverse reactions for student NOT prescribed_____

_____

Special instructions_____

_____

Procedures for school employees if student is unable to administer the medication or if it does not produce the expected relief_____

ANTIHISTAMINE: (name & dose in mg)

_____

Route to be given_____

Time & frequency to be given_____

_____

Date to begin:_____ Date to end: _____

Adverse reactions for student prescribed_____

_____

Adverse reactions for student NOT prescribed_____

_____

_____As the prescriber, I have determined that this student ***is capable*** of possessing and using the auto injector and antihistamine as needed for treatment of an allergic reaction. The student has been provided training in the proper use of the auto injector and antihistamine administration.

_____As the prescriber, I have determined that this student ***is not*** capable of possessing and using this auto injector appropriately and administration of this medication may be supervised by medically untrained personnel, it is requested that the medication be given at school by school personnel.

Physician Name: _____ Phone #: _____Fax #:_____

Physician Signature: _____ Date: _____

***** ORDERS MUST BE RENEWED EVERY SCHOOL YEAR *****

9/2019