MARYSVILLE
Exempted Village School District

Dear Parent/Guardian,

You are receiving this letter because you have indicated that your child has a severe allergy requiring emergency care. Enclosed are the forms to be completed by you and your child's healthcare provider to ensure continuity of care while at school. Once completed, please return the forms indicated in the checklist below to the health clinic at your child's school. The forms will need to be completed each school year.

Severe Allergy Checklist

- ☐ ***Administration of Medication Request (Form MEVS H-2)***
  (Must be completed by the healthcare provider and signed by the parent/guardian)

- ☐ ***FARE Food Allergy & Anaphylaxis Emergency Care Plan***
  (Must be completed by the healthcare provider and signed by the parent/guardian)

- ☐ ***Medical Directive for Nutrition***
  (Completed by the healthcare provider and signed by the parent/guardian, IF there are diet modifications needed)

- ☐ ***Allergy Questionnaire***
  (Completed by the parent/guardian)

- ☐ ***Physician ordered medication(s) in its original container***

Please be aware that only if requested by a physician under "special storage conditions" on the "Administration of Medication Request" form a student may carry an epinephrine autoinjector with him/her in a personal bag/backpack to and from school daily. In addition, if your child is in possession of his/her epinephrine autoinjector a backup epinephrine autoinjector will need to be kept in the clinic.

If you have any questions, please contact the health clinic at your child's school.

Thank you,
Health Services

MARYSVILLE
Exempted Village School District
Innovate Collaborate Inspire

Board of Education
1000 Edgewood Dr.
Marysville, OH 43040

Office 937-578-6100
Fax 937-578-6113

www.marysville.k12.oh.us

ADMINISTRATION OF MEDICATION REQUEST(Form MEVS H-2)

This form must be completed by both the physician who prescribes the medication and the parent or guardian of the student prior to school personnel being permitted to administer medication.

PHYSICIAN'S REQUEST (all items MUST be completed)

____
NAME OF STUDENT – Print **DOB**

____
Complete Address **Phone**

is under my care for **(Condition)** ______________________________

and should receive **(Exact Name of Drug)** ______________________________

in the following dosage **(Exact Amount)**______________________________and route______________

at the following time(s) **(Exact Hours)** ______________________________

Beginning on (date) ______________ and ending on (date) ______________

This medication may cause the following adverse reactions which should be reported to the undersigned immediately

____

This medication requires the following special storage or sterile conditions (note: the school will provide storage for drugs needing refrigeration)

____

Physician's Name (Print) ______________________________

Physician's Complete Address ______________________________

Office Telephone ______________________________ Alternate Emergency Phone No ______________

Physician's Signature______________________________**Date**______________

PARENT OR GUARDIAN'S REQUEST

____
NAME OF STUDENT – Print Building/Class Grade

I ______________________________ parent/guardian of ______________________________
Parent/Guardian – Print Student's Name – Print

Hereby request and give my consent to any employee of the School Board who has been duly authorized by the Board to administer the medication prescribed as directed by the physician or parent, for the following prescription drug

____to my child.
Exact Name of Drug

I also agree to comply with the Ohio law which requires me to deliver the medication to the school in its original container and to comply with the guidelines of school Board policy which requires me to receive the medication at its expiration date or the end of the school year, whichever occurs first and any other procedures which the Board may establish.
I also agree to submit to the school a revised statement signed by the physician named above if any of the information contained in the PHYSICIAN'S REQUEST changes.

Parent/Guardian's Signature ______________________________**Date**______________

This medication request form has been properly completed by both the physician and the parent/guardian, and the school will administer the medication as outlined.

Principal's or Designee's Signature ______________________________**Date**______________

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________________ D.O.B.: ______________

Allergic 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.

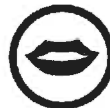
FOR **ANY** OF THE FOLLOWING:

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): ______________

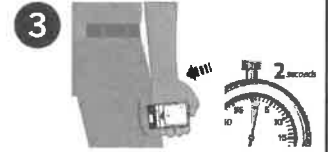
____

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

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

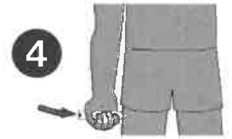
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



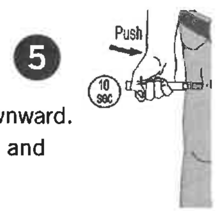
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, 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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



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



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. 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. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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: ______________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Marysville Exempted Village School District
Department of Food and Nutrition

Medical Directive for Nutrition

Please fill out this form in its entirety to ensure adequate care

Part A

Student name ____ Age __________

Name of School:

_____ Bunsold Middle School
_____ Creekview Intermediate School
_____ Early College High School
_____ Edgewood Elementary
_____ Marysville High School
_____ Tri Academy
_____ Mill Valley Elementary
_____ Navin Elementary
_____ Northwood Elementary
_____ Raymond Elementary

Grade Level ________________ Classroom ______________________

Does the child have a disability? Yes No
If yes, please describe the major life activities affected by the disability. ___________________________
____
____
____

Does the child have special nutritional or feeding needs? Yes No
If yes, please complete Part B of this form and have it signed by a licensed physician.

If the child is not disabled, does the child have special nutritional or feeding needs? Yes No
If yes, please complete Part B of this form and have it signed by a recognized medical authority.

If the child **does not** require special meals, the parent can sign at the bottom and return the form to the school food service.

Part B

List any dietary restrictions or special diet. ____
____
____
____

List any allergies or food intolerances to avoid. ____
____
____
____

List **all** foods to be substituted. ____
____
____
____
____
____

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".

Cut in bite size pieces	Chopped	Finely Ground	Pureed

List any special equipment or utensils that are needed: ______________________________________
____
____
____

Indicate any other comments about the child's eating or feeding patterns: ______________________
____
____
____

Parent Signature ____ Date ____________________

Physician Signature ______________________________________ Date ____________________

Medical Authority Signature _________________________________ Date ____________________

<u>For Food Service use only</u>
Date received ______________________ Building receiving form ____________________

Name of food service personnel receiving ________________________
Title of person receiving form _________________________________

Notes ____
____

Document modeled after provided information from ODE form

Allergy Questionnaire

Student Name: ______________________________ Date of Birth: ______________

1. **Does your child have a diagnosis of an allergy from a healthcare provider?** ☐ Yes ☐ No
2. **Allergies:** Check all that apply. Name the specific food, insect, etc. causing the reaction:

☐ Tree Nuts Specifically: ______________________________
☐ Peanuts
☐ Fish/Shellfish Specifically: ______________________________
☐ Dairy Products Specifically: ______________________________
☐ Soy Specifically: ______________________________
☐ Insect Stings Specifically: ______________________________
☐ Chemicals Specifically: ______________________________
☐ Vapors Specifically: ______________________________
☐ **Other** Specifically: ______________________________

3. **My child has a reaction when he/she:**

☐ Eats the food or another food containing the food allergen.
☐ Touches a surface contaminated.
☐ Breathes odors from the food allergen while the food is being cooked or processed.
☐ Other: ______________________________

4. **Symptoms my child has when in contact with the allergen includes:**

☐ Nausea and vomiting
☐ Cramping/Abdominal pain
☐ Facial Swelling, itching, welts or hives
☐ Respiratory changes, difficulty breathing, wheezing, continuous coughing
☐ Inability to speak or swallow
☐ Flushed face
☐ Drooling
☐ Complains that the throat feels tight, scratchy
☐ Other- describe:______________________________

5. **Onset of symptoms:**

☐ Immediately
☐ Within 15 minutes
☐ Within one hour
☐ Up to two hours

6. **History:**

Age of student when allergy was first discovered: ______________________________
How many times has the student had a reaction? ______________________________
Has an epinephrine autoinjector been administered to your child in the past? ☐ Yes ☐ No
Explain past reaction(s): ______________________________
____
How were the past reactions treated? ______________________________
How effective was the student's response to treatment? ______________________________
Was there an emergency room visit? ☐ No ☐ Yes, explain: ______________________________

7. **Allergy Action Plan**

Has your child been prescribed an epinephrine auto-injector (i.e. Epipen, Auvi-Q)? ☐ Yes ☐ No

If prescribed, where would you want your child to keep his/her epinephrine auto-injector during the school day?

☐ Health Office ☐ With him/her

Does your child need to sit at a peanut/nut free table at lunch? ☐ Yes ☐ No

Transportation: ☐ Medication available on bus ☐ Medication is NOT on available on bus ☐ N/A

8. **Self-Care**

Does your child:

Know what foods to avoid?	☐	No	☐	Yes
Read and understand food labels?	☐	No	☐	Yes
Tell an adult immediately after an exposure?	☐	No	☐	Yes
Firmly refuses a problem food?	☐	No	☐	Yes
Know how to use emergency medication?	☐	No	☐	Yes
Has your child ever administered their own emergency medication?	☐	No	☐	Yes

9. Is there anything else that you would like for school personnel to know about your child's allergy?

____

____

____

____

Memo of Understanding

1. It is a mutual responsibility of the parent and teacher to review party or field trip menus.
2. It is understood that food servers are taught how to prevent cross contamination during food preparation and when serving food in the lunch line.
3. It is the responsibility of the parent to review the lunch menu with their child.
4. It is understood that school personnel will not give your child a food without your approval at school.
5. It is understood that the parent will provide the emergency medications needed at school, accompanied by the parent and physician signed Medication Administration Form and Action Plan.
6. It is understood that only if requested by a physician under "special storage conditions" on the "Administration of Medication Request" form, a student may carry emergency medication with him/her in a personal bag/backpack to and from school daily.
7. It is understood that, if your child should possess his/her epinephrine autoinjector, that a backup epinephrine autoinjector will be kept in the health clinic.
8. It is the responsibility of the parent to notify the health clinic staff of changes in the health plan.

Parent Permission

I verify that the above information is correct. I give permission to share this information with staff on a need to know basis.

Parent/Guardian Signature: ______________________________ Date: __________

Reviewed by: ______________________________ Date: __________