



Westerville City Schools

936 Eastwind Drive, Westerville, OH 43081
Main Office (614)797-5700, Fax (614)797-5701

Waalidka/Mas'uulka Qaaliga ahoow,

Sida ay muujinayaan diiwaanadayada caafimaadka, ardaygaaga waxaa taariikhda ugu jira inuu qabo Xasaasiyad Daran. Haddii ilmahaagu u baahan yahay inuu heli karo daawada xasaasiyadda inta uu dugsiga ku jiro, fadlan buuxi kuwan soo socda:

1. Qorshaha Waxqabadka Xasaasiyadda (waxaa lagu beddeli karaa foomka bixiyaha caafimaadka haddii dhammaan macluumaadka lagu daro) - Waa inay buuxiyaan oo ay saxiixaan bixiye caafimaad IYO waalidka/masuulka.

2. In Ardayga loo ogolaado inuu Haysto oo Isticmaalo dawada xasaasiyadda ee tooska la iskaga duro (Epinephrine Auto-Injector) - Haddii aad jeclaan lahayd in ardaygaagu uu qaato daawada toos-isku-duro ee epinephrine inta lagu jiro saacadaha dugsiga, waa in bixiyaha caafimaadka iyo waalidku ay foomka soo buuxiyaan oo saxiixaan. Fadlan ogow: Haddii aad doorato ikhtiyaarka in ilmahaaga iskii uu qaato daawada, waa inaad Cirbadda Toos-Isku-Durida ee Epinephrine oo dheeraad ah aad keentaa si loogu hayo Rugta Cafimaadka ee iskuulka.

3. Codsiga In la Siiyo Ardayga Dawo Qoran Inta Lagu Jiro Saacadaha Dugsiga - Dhammaan daawoyinka riijeeto la'aanta laga gato rugta caafimaadka waa in ay haystaan oo galka uu ku jiro amarka bixiyaha oo saxiixan. Haddii uu ilmahaagu u baahan yahay dawo marka laga reebo Epinephrine, sida antihistamine (ie. Benadryl, Zyrtec), fadlan dhakhtarkaaga ka codso inuu foomkan buuxiyo oo saxiixo. Waalidka/masuulku waa inuu sidoo kale foomkan saxiixaa.

4. Foomka Wax ka beddelka Cuntada Kafateeriyada - Haddii ilmahaagu u baahan doono cunto gaar ah sida beddelka cuntada ee kafateeriyada, fadlan weydiiso dhakhtarkaaga inuu buuxiyo oo saxiixo foomkan. Waalidka/masuulku waa inuu sidoo kale foomkan saxiixaa. Haddii aad jeclaan lahayd nuqul ka mid ah Hagaha agabyada Dugsiyada Magaalada Westerville ee Kaalmaynta Carruurta qaba Xasaasiyadda Nafta Halista galisa, fadlan u sheeg kalkaalisada dugsigaaga. Waxa kale oo laga heli karaa mareegaha degmada dugsiga qaybta hoos timaada Adeegyada Caafimaadka.

Fadlan wixii su'aalo ama walaac aad qabto la xirii rugta caafimaadka ee dugsiga.
Si daacadnimo leh,

Kalkaalisooniyinka Degmo Dugsiyeedka Magaalada Westerville

Qorshaha Waxqabadka Xasaasiyada ee Degmo Dugsiyeedka Magaalada Westerville

Miisaanka: _____ rodol Neef: Haa (khatarta sare ee falcelinta daran) Maya

MID UN KA MID AH KUWAN HOOSE:

SAMBABKA: Neefta oo yaraata, hiinraag, qufac soo noqnoqda

WADNAHA: Maqaarka oo guduuto ama buluug ah, daal, garaaca wadnaha oo daciif ah, dawakhaad

CALOOSHA: Matag soo noqnoqda, shuban daran

DHUUNTA: Cunaha oo ciriiri noqdo ama xabeeb leh, neefsashada ama liqidda oo dhib noqota

WAX KALE: Dareenka wax xun inay dhici doonaan, walaac, jahawareer

AFKA: ISKU-DARKA calaamadaha ka yimaada meelo kala duwan oo jirka ah.

2. Wac telefoonka 911. U sheeg soo diraha gurmada in qofka uu qabo falcelin xasaasiyadeed-daran oo laga yaabo inuu u baahdo epinephrine marka ay gurmada degdega ahi yimaadaan.

- Tixgeli ama iskuday inaad siiso daawooyin dheeri ah kadib epinephrine:
 - » Neefsiiyeyaasha (bronchodilator) hadduu hiinraag jiro
- Qofka si fidsan ujiifi, lugaha kor u qaad oo diirri. Haddii ay neefsashadu ku adag tahay ama ay matagayaan, fadhiisi ama dhinac u jiifi.
- Haddii calaamaduhu aysan soo roonaan, ama calaamaduhu soo noqdaan, qiyaas/dawo dheeraad ah oo epinephrine ah ayaa la siin karaa qiyaastii 5 daqiiqo ama ka badan ka dib marka laga joogo dawadii ugu dambeysay ee la siiyay.
- Ogaysii dadka xiriirka deg dega ah kujira.
- Bukaanka u qaad Qolka Degdegga (ER), xitaa haddii ay calaamaduhu soo roonaadaan. Bukaanku waa inuu Qolka Degdegga (ER) ku jiraa ugu yaraan 4 saacadood maadaama calaamaduhu soo noqon karaan.

BUKAANKA AMA WAALIDKA/MAS'UULKA AH
SAXIIXA OGGOLAANSAHA _____ TAARIIKHDA _____

OGGOLAANSHAHA DHAKHTARKA/HCP
SAXIIXA _____ TAARIIKHDA _____

Waaxda Caafimaadka Ohio

Oggolaanshaha Ardayga ee Haysashada iyo Isticmaalka dawada xasaasiyadda ee Tooska la Iskugu Duro (Epinephrine Auto-Injector)

Sida waafaqsan ORC 3313.718/3313.141

Qaybtan waa in uu buuxiyaa oo uu saxiixaa waalidka ama masuulka ardayga.

Anigoo ah Waalidka/Mas'uulka ardaygan, waxaan ilmahayga u fasaxayaa inuu dawada epinephrine autoinjector sida loogu soo qoray uu ku haysto oo ku isticmaalo, dugsiga iyo hawl-qabadyada dugsiga, munaasabada, ama barnaamij kasta oo uu dugsigu qabanayo ama uu dugsiga ardaygu uu ka qayb galayo. Waxaan fahamsanahay in shaqaalaha dugsigu uu isla markaaba caawinaad ka codsan doono bixiyaha adeegga caafimaadka degdegga ah haddii daawadaan la siinayo. Waxaan maamulaha dugsiga ama kalkaalisada u dhiibi doonaa daawada kayd ah sida uu sharcigu qabo.

Saxiixa Waalidka/Masuulka	Taariikhda
Magaca Waalidka/Masuulka	Lambarka taleefanka degdegga ah ee Waalidka/Masuulka ()

Magaca iyo qiyaasta daawada	
Taariikhda isticmaalka daawadu bilaabmayso	Taariikhda isticmaalka daawadu ay dhammaanayso (haddii la garanayo)

Fal-celin xasaasiyadeedka aadka udaran ee suurtagalka ah:

La siiyo ardayga dawada loo qoray (oo ah in lagu wargeliyaa cidda u qortay)

La siinayo ardayda **aan dawada loo** qorin

Tilmaamaha gaarka ah

Saxiixa cidda u qortay	Taariikhda
Magaca cidda u qortay	Taleefanka degdegga ee cidda u qortay ()

Waxaa la sameeyay iyadoo lala kaashanayo Ururka Kalkaaliyeyaasha Dugsiga ee Ohio.

DUGSIYADA MAGAALADA WESTERVILLE

CODSIGA IN ARDAYGA LA SIIYO DAAWADA LOO QORAY SAACADAHA DUGSIGA LAGU GUDA JIRO
Sida Uu Farayo Qaybta 3313.713 ee Xeerka Dib Loo Eegay

Cinwaanka Guriga Ardayga: _____

QEYBTA WAALIDKA

1. Foomkan waa in waalidka (qaybta sare) iyo cidda qortay daawada (qaybta hoose) ay labaduba buuxiyaan
2. Daawada waa in lagu hayaa dhalada **daawada lagu calaamadayeeyay ee ardayga**. (Waxaa dhici karta in farmashiyuhu bixiyo dhallo dheeraad ah loona isticmaalo daawada la isticmaalayo muddada dheer.) Calaamadaynta daawadu waa in ay waafaqdaa tilmaamaha dhakhtarka dawada qoray. Haddii ay tahay daawo aan la soo qorin, waa in ay ku jirto weelka asalka ahaa.
3. Waa in waalidka/masuulka ama qof kale oo weyn oo mas'uul ah oo waalidku ka codsadey uu shaqaalaha rugta caafimaadka ee dugsiga uu toos ugu geeyaa kayd daawo la isticmaalo wax aan ka badnayn 2-4 toddobaad. Tani waa in horay loo habeeyo.
4. Haddii wax isbedel ah uu jiro waa in qoraal saxiixan dhakhtarka laga keeno. Foom cusub ayaa loo baahan yahay sannad dugsiiyeed kasta.

Marka ay suurtoagal tahay, sii daawada wakhti ka baxsan saacadaha dugsiga. *OGGOLAANSHAHA: Aniga, waxaan u fasaxay Shaqaalaha Dugsiga inay si toos ah ula xiriiraan dhakhtarka haddii ay dhacdo fal-celin xasaasiyadeed oo darran oo degdeg ah sida hoos ku xusan. Oggolaanshahani ma beddelayo mana tirtirayo "Foomka Caafimaadka Degdegga ah".

Saxiixa Waalidka: _____ Taariikhda: _____
Saxiixa waalidku waxa uu u fasaxayaa shaqaalaha dugsiga in ay daawada hoos ku qoran siiyaan.

Lambarka taleefanka waalidka: _____
Wakhtiga maalintii _____ Fiidkii _____

QEYBTA DHAKHTARKA

Waxaan xaqiijinayaa in daawadan ay tahay in uu qaato: _____
Magaca Ardayga _____

DAAWOYINKA MAALINLAHA AH (Marka ay suurtoagal tahay, fadlan isku day inaad jadwal usamayso dawada ka baxsan saacadaha dugsiga)

DAAWADA	QIYAASTA	SIDA LOO SIINAYO	WAKHTIGA LA SIINAYO

DAAWOYINKA LOO ISTICMAALO HADBA SIDA LOOGU BAAHDO

DAAWADA	QIYAASTA	SIDA LOO SIINAYO	WAKHTIGA U DHEXEYYA QIYAASAHA DAWADA LA QAADANAYO

Baaritaanada daawada loogu qoray?	
Wixii Falcelin xasaasiyadeed daran ah ee ay tahay in dhakhtarka loo sheego*?	
Tilmaamaha gaarka ah ee siinta daawada, oo ay ku jiraan xaaladaha nadaafadda iyo kaydinta?	
Taariikhda iskuulka laga bilaabay siinta daawada:	Taariikhda dhicidda:

X
Saxiixa Dhakhtarka dawada Qoray _____ Taariikhda _____

Magaca qoran ee dhakhtarka dawada qoray: _____ Taleefanka: _____

Ciwaanka dhakhtarka dawada qortay: _____

Haddii faakis ahaan loogu diro dugsiga, waa mas'uuliyadda waalidka in uu hubiyo in la helay

FAKIS LAMBAR: _____



Bayaanka Caafimaadka ee Sooridda Cuntada Gaarka ah

Tilmaamaha Waaxda Beeraha ee Maraykanka waxay uga baahan yihiin maamulka cuntada ee dugsiya ee ka qayb qaadanayo Barnaamijka Qadada Dugsiga Qaranka in ay u sameeyaan maamusiid macquul ah oo la siiyo ardayda naafada ah, iyadoo loo eegayo xaaladaha gaarka ah, marka baahida lagu caddeeyo bayaan caafimaad oo qoran.

Sharciga Waxka bedelka 2008 ee Muwaadiniinta Maraykanka ee Naafada ah (ADA, Americans with Disabilities) (Sharciga Dadweynaha 110-325, 42 U.S.C. 12101) ayaa cusboonaysiiyay qeexida naafada si ay ugu daraan "qof kasta oo qaba naafo jireed ama maskaxeed oo si xad dhaaf ah u xaddidaysa hal ama wax ka badan hawlo nololeedka muhiimka ah ee shakhsiyeed", oo ay ku jiraan hawlaha mugga leh ee jireed sida hawl nololeed mug leh.

Marka loo eego USDA, maamulka cuntada dugsiya loogama baahna inay buuxiyaan codsiyada cuntada gaarka ah ee ku salaysan dookhyada cuntada ee aan loo tixgelin xaalado caafimaad ama naafo, oo ay ku jiraan doorashooyinka qaab nololeedka shakhsiyeed (sida dadka khudaarka kaliya cuno, cunidda khudrad kali ah, cunidda cunto dabiici ah kaliya) ama ikhtiyaarada cuntooyinka diinta la xariira.

Foomkan waa in uu buuxiyaa takhtar, kaaliye takhtar, ama kalkaaliye caafimaad oo shati dawlad-goboleed haysta. Cusboonaysiinta foomkan ayaa loo baahan yahay kaliya marka baahiyaha ka qaybqaataha ay isbedelaan.

Macluumaadka ka qaybqaataha

Magaca Ka qeybqaataha: _____ Taariikhda Maanta: _____
 Magaca Dugsiga La Dhigtay/Fasalka: _____ Taariikhda Dhalashada: _____
 Magaca Waalidka/Mas'uulka: _____
 Lambarka Taleefanka Guriga: _____ Lambarka Taleefanka Shaqada: _____

Macluumaadka Loo Baahan Yahay: Maamuusidda Cuntada

1. Cuntada xasaasiyadda kugu dhaliso ama cuntada la iska ilaalinayo-goobo geli dhammaan kuwa khuseeya:
 Caano subag-laws geedaha lawska ukumaha kalluunka kallunka sheelfiish qamadi digirta
 guluteen sisin cuntooyin kale _____

2. Sharaxaad kooban oo ku saabsan sida soo-cunista cuntadani u saamayso ka-qaybgalaha:
 Neefsiga _____
 Shaqada muhiimka ah ee jireed (habdhiska difaaca, mindhicirka, dheefshiidka, iwm.) _____
 Wax kale, qeex: _____

3. Ardaygu ma cuni karaa cuntooyin uu ku jiro cuntada uu xasaasiyadda ku yahay? _____ haa _____ maya
 (Tusaale: ukunta la shillay waa inaan la siinin laakiin malawaxa/bankeega ukunta lagu sameeyay waa la oggol yahay)

Fiiro gaar ah:

4. **WAAJIB AH:** Cuntada lagu badali karo (FIIRO GAAR AH: WCS ma qadarin karto dukumeentigan ilaa in BEDELLO GAAR AH hoos lagu taxo mooyaane, ama dhakhtarku uu ardayga u gudbiyo cunto yaqaan diiwaangashan kaas oo tilmaamo ka bixiya liiska dookhyada cuntada.)

Waxaan xaqiijinayaa in ardayga kor lagu xusay uu u baahan yahay wax ka laga beddelo cuntadiisa oo loogu beddelo cunto kale sababo la xariira xaalad naafonimo ama xaalad caafimaad owgood.

Saxiixa Bixiyaha Caafimaadka

Taariikhda

Taleefanka

Waxaan u fasaxay Adeegga Cunnada WCS inay samayso beddelkan cuntada ee caafimaad ahaan loo baahan yahay.

Saxiixa Waalidka/Masuulka

Taariikhda

Iyadoo la raacayo sharciga xuquuqda madaniga ah ee federaalka iyo siyaadaha iyo qawaaniinta xuquuqaha madiga ah ee Waaxda Beeraha ee Maraykanka (USDA), USDA-da, wakaaladaheeda, xafiisyadeeda iyo shaqaalaha, iyo machadyada ka qayb qaadanaya ama maamulaya barnaamijyada USDAwaa ka mamnuuc inay sameeyaan takoor ku salaysan isirka, midabka, asalka qaran, jinsiga, diinta caqiidada, naafonimada, da'da, aaminsanaanta siyaasadeed, amaargoosiga ama aarsiga ku salaysan hawlaha rayidka ee hore eebarnaamij kasta ama hawlo ay qabatay ama maalgalisay USDA. Dadka qabo naafonimada ee u baahan qaab kale ee isgaarsiin ee macluumaadka barnaamijka (tusaale ahaan Indhoolaha, Farta waawayn, cajalado-maqal ah, Luuqadda Dhagoolaha ee Maraykanka, iwm.), waa inay la xiriiiraan Wakaaladda (gobolka ama dawlad deegaanka hoose) ee ah halka ay ka dalbadeen dheefaha. Shakhsiyadka dagooolaha ah ay ku, adag tahaymaqalka ama naafo ka ahdhalka waxay la xiriiri karaan USDA iyagoo u marayo Adeegga Gaarsiinta Faderaalka ee lambarka (800) 877-8339. Intaa waxaa dheer, macluumaadka barnaamijka ayaa lagu heli karaa luuqado aan ahayn luuqadda Ingiriiska. Si aadu gudbisno cabasho barnaamij ee ahtakoord, buuxi Foomka Cabashada Takoorka ee Barnaamijka USDA, (AD-3027) ee looga heli karo si onlayn ah barta:

http://www.ascr.usda.gov/complaint_filing_cust.html, iyo goob kasta ee xafiiska USDA ah, ama u qor warqad aad u diraysu cinwaanka USDA oo ku qor gudaha warqadda dhammaan wixi macluumaad ahee lagaaga codsaday gudaha foomka. Si aad u codsato nuuqkamid ah foomka cabashada, **wac** (866) 632-9992. U gudbi foomkaaga aad dhamaystirtay ama warqada aad u diraysu boostada USDA: U.S. Waaxda Beeraha Xafiiska Kaaliyaha Xoghayaha ee Xuquuqaha Madaniga ah



Westerville City Schools

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Vision

Our vision is to be the benchmark of educational excellence.

Mission

Our mission is to prepare students to contribute to the competitive and changing world in which we live.

Values

Respect
Inclusiveness
Community
Communication
Collaboration
Innovation
Nurturing
Trust
Accountability

Dear Parent/Guardian,

According to our health records, your student has a history of **Severe Allergies**. If your child requires medication to be available to them while at school for allergy treatment, please complete the following:

1. **Allergy Action Plan** (may be substituted with medical provider's form if all information included) - Must be completed and signed by medical provider AND parent/guardian.
2. **Authorization for Student Possession and Use of an Epinephrine Auto-injector** - Medical provider and parent must complete and sign if you would like your student to carry their epinephrine auto-injector with them during school hours. Please note: If you choose the self-carry option for your child, you must provide an additional Epinephrine Auto-Injector to be kept in the clinic.
3. **Request to Administer Prescribed Medication to a Student During School Hours** - All over the counter medication kept in the clinic must have a provider's signed order on file. If your student requires medication in addition to Epinephrine, such as an antihistamine (i.e. Benadryl, Zyrtec), please request your medical provider complete and sign this form. A parent/guardian must also sign this form.
4. **Cafeteria Diet Modification Form** - If your child will need a special diet such as food substitutes from the cafeteria, please ask your medical provider to complete and sign this form. A parent/guardian must also sign this form.

If you would like a copy of the *Westerville City Schools Resource Guide for Supporting Children with Life-Threatening Allergies*, please let your school nurse know. It can also be found on the school district's website under Health Services.

Please contact the school health clinic with any questions or concerns.

Sincerely,

Westerville City School District School Nurses

Revised August 2022

Westerville City Schools Allergy Action Plan

**PLACE
PICTURE
HERE**

Name: _____ D.O.B.: _____

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
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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: 0.15 mg IM 0.3 mg IM

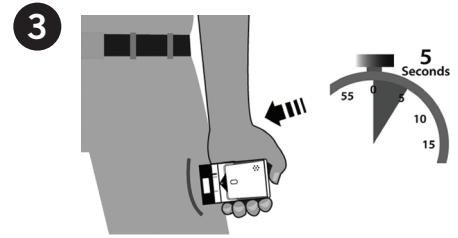
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

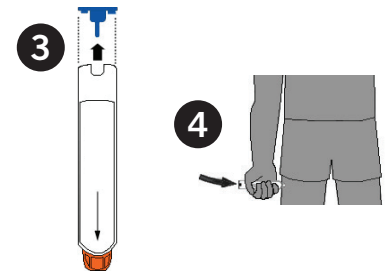
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



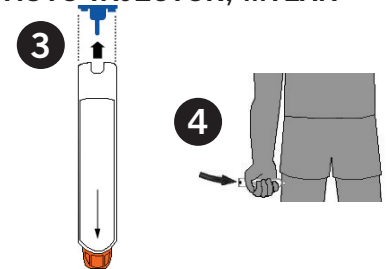
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.



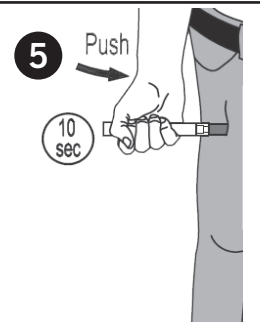
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine 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 ADRENALICK®), 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.



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: _____

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, 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.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ()

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Circumstances for use of the epinephrine autoinjector	
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 reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is not prescribed who receives a dose
Special instructions

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.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ()

WESTERVILLE CITY SCHOOLS

REQUEST TO ADMINISTER PRESCRIBED MEDICATION TO A STUDENT DURING SCHOOL HOURS

As Required By Section 3313.713 Ohio Revised Code

Student Name: _____ Date of Birth: _____

Student Address: _____

School: _____ Grade: _____ Teacher: _____

PARENT SECTION

1. This form must be completed by both the parent (top section) and the prescriber (bottom section)
2. Medication must be kept in the **student's prescription labeled bottle**. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instructions from prescriber. If it is a non-prescription drug, it must be in the original container.
3. Deliver no more than 2 -4 weeks supply of medication to school clinic staff directly by the parent/guardian or other responsible adult at parental request. This should be arranged in advance.
4. A revised statement signed by the prescriber must be provided for any changes. A new form is required every school year.

When possible, give medication outside of school hours. *CONSENT : I, give consent for School Staff to make direct contact with the prescriber should an emergency adverse reaction indicated below occur. This consent does not supersede nor abrogate the "Emergency Medical Form".

Signature of parent: _____ Date: _____
 Parental signature authorizes school personnel to administer the below prescribed medication.

Parent phone number: _____
 _____ Day time _____ Evening

PHYSICIAN SECTION

I verify that this medication must be taken by: _____
 _____ Name of Student

FOR DAILY MEDICATIONS (When possible, please attempt to schedule medication outside of school hours)

DRUG	DOSE	ROUTE	TIME TO BE GIVEN

FOR AS NEEDED MEDICATION

DRUG	DOSE	ROUTE	TIME INTERVAL BETWEEN DOSES

Diagnosis for which medication is prescribed?	
Any severe adverse reactions that should be reported to the prescriber *?	
Special instructions for administration, including sterile conditions and storage?	
Start date to administer at school:	Expiration date:

X
 Prescriber's Signature _____ Date _____

Prescriber's Printed Name: _____ Phone: _____

Prescriber's Address: _____

If faxed to school, it is the parent's responsibility to ensure it is received **FAX NUMBER:** _____



Westerville City School District

Medical Statement for Special Diet Accommodations

The United States Department of Agriculture guidelines require school food authorities participating in the National School Lunch Program to make reasonable accommodations available to students with disabilities, on a case-by-case basis, when the need is supported by a written medical statement.

The Americans with Disabilities (ADA) Amendments Act of 2008 (Public Law 110-325, 42 U.S.C. 12101) updated the definition of a disability to include "anyone with a physical or mental impairment that substantially limits one or more major life activities of that individual", including major bodily functions as a major life activity.

According to the USDA, school food authorities are not required to accommodate special diet requests based on dietary preferences that are not considered medical conditions or disabilities, including personal lifestyle choices (such as vegan, vegetarianism, organic) or religious choices.

This form must be completed by a state licensed physician, physician assistant or nurse practitioner. Updates to this form are required only when a participant's needs change.

Participant Information

Participant's Name: _____ Today's Date: _____
Name of School Attended/Grade: _____ Date of Birth: _____
Parent/Guardian Name: _____
Home Phone Number: _____ Work Phone Number: _____

Required Information: Dietary Accommodation

1. Allergen or food to be avoided-circle all that apply:
Milk peanuts tree nuts eggs fish shellfish wheat soy gluten sesame other _____

2. Brief explanation of how exposure to this food affects the participant:
Breathing _____
Operation of major bodily functions (immune system, bowel, digestive, etc.) _____
Other, specify: _____

3. Can the student consume foods where the allergen is an ingredient in the food product? ____yes ____no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)

Notes:

4. **MANDATORY:** Food to substitute (NOTE: WCS cannot honor this document unless SPECIFIC SUBSTITUTIONS are listed below or physician refers student to registered dietitian who specifies menu items.)

I confirm the student listed above requires stated diet modifications and substitutions due to disabilities or medical conditions.

Medical Provider Signature Date Phone

I authorize WCS Food Service to make this medically required dietary modification.

Parent/Guardian Signature Date