



Aurora City Schools

www.aurora-schools.org

Board of Education
102 E. Garfield Rd.
Aurora, OH 44202
330-562-6106
Fax: 330-562-4892

Miller Elementary
646 S. Chillicothe Rd.
Aurora, OH 44202
330-562-6199
Fax: 330-995-5459

Craddock Elementary
105 Hurd Rd.
Aurora OH 44202
330-562-3175
Fax: 330-954-2087

Leighton Elementary
121 Aurora-Hudson Rd.
Aurora OH 44202
330-562-2209
Fax: 330-562-2265

Harmon Middle School
130 Aurora-Hudson Rd.
Aurora OH 44202
330-562-3375
Fax: 330-562-4796

Aurora High School
109 W. Pioneer Trail
Aurora OH 44202
330-562-3501
Fax: 330-562-3588

Allergic Reactions

Dear Parent/Guardian

You have told us that your child can have an allergic reaction. In preparation for the upcoming school year, the following forms must be completed.

1. Allergy history: completed each school year by Parent
2. Allergy Action Plan and Medication for Anaphylaxis: completed each school year and signed by Physician and Parent
3. Preschool, Kindergarten, and/or new student to District: Please attach a small picture to this packet.

All medications must be in their original containers. Medication MAY NOT be sent to school with the student (unless they are approved to self carry). Parent/Guardian to deliver medication to school.

If you choose not to have emergency medication available at school, please notify the nurse in your child's building.

Please call your child's designated school clinic if you have questions, we would be happy to help you.

**Aurora City School District
Allergy History**

Student Information

Student Name	Grade
Allergy	

Reaction History

How many reactions to this allergen has your child experienced?	When was your child's most recent allergic reaction
Describe your child's typical symptoms during an allergic reaction. -----	

Treatment

How have past reactions been treated (include medications administered)? -----

Medication at School

I will provide the school with emergency medication (your physician will need to complete the appropriate Medication Administration form and Action Plan)	YES	NO
My child will carry his medication, whether it be on his person or in his backpack (your physician will need to approve this on the appropriate Medication Administration form)	YES	NO

Food Allergies

Peanut and/or Nut Allergies	Egg Allergy	Dairy Allergy
My child may eat packaged food that does not contain peanuts and/or nuts, but is processed in a facility that uses peanuts and/or nuts.	My child may eat food items that egg baked into The item. (cookies, muffins, biscuits)	My child may eat food items that have dairy baked into the item. (cookies, muffins, biscuits).
YES NO	YES NO	YES NO
My child will need to sit at the "Peanut/Nut Free" table at lunch. Any child may sit at these designated tables as long as he/she is not eating food containing peanuts or nuts.	If no, please list a safe substitute:	If no, please list a safe substitute:
YES NO		

Parent/Guardian Authorization

All school Health information is handled in a respectful and confidential manner. May the nurse share the above information with school staff on a "need to know" basis?	YES	NO
May we share your child's food allergy with your child's classroom? We will not use your child's name, but will inform the parents that a child with a food allergy is in the classroom and to please refrain from sending in snacks with this food ingredient.	YES	NO
Parent/Guardian Signature	Date	

Individualized Health Action Plan- Severe Allergy

Student Name _____

Allergy _____

Student
Photo

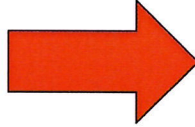
Any SEVERE SYMPTOMS

After suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheezing, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

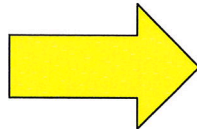
Or combination of symptoms from different body areas
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Mild nausea/discomfort



1. Give _____
2. Call 911
3. Alert School Nurse and Parent
4. Begin monitoring (see box below)
5. Give additional medications as ordered:

MILD SYMPTOMS ONLY:

MOUTH: Itchy Mouth
SKIN: A few hives around mouth/face, itch
GUT: Mild nausea/discomfort



1. Give _____
2. Stay with student; alert School Nurse and Parent
3. If symptoms progress (see RED box above)
4. Begin monitoring (see box below)

If checked, give epinephrine immediately even if no symptoms and exposed to allergen

Monitoring: Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given: request an ambulance with epinephrine. Note the time when epinephrine was administered. A second dose of epinephrine can be given five minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping the student lying on back with legs raised. Treat students even if parents cannot be reached.

Foods to Avoid

Specific to student

Individual notes:

Specific to student

Symptoms experienced in the past:

Specific to student

Prescriber signature _____ Date _____

Parent signature _____ Date _____

Please make sure physician medication authorization form is completed with physician signature

Aurora City Schools Medication for Anaphylaxis (Severe Allergy)

Student Information

Student Name:		Date of birth:
Address:		
Weight	Asthma	<input type="checkbox"/> YES (Higher risk for a severe reaction) <input type="checkbox"/> No
List any allergies:		

Prescriber Authorization

Epinephrine (brand and dose):	
Antihistamine (brand and dose):	
Other (e.g., zofran, inhaler-bronchodilator if asthmatic):	
Date to begin medication	Date to end medication
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	
Special instructions	
Authorization is hereby given for the student named above to (please initial)	
_____ 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	
_____ Receive the prescribed medication indicated from the designated school personnel	
Prescriber signature	Date
Prescriber name	
Phone	Fax

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I understand that according to Aurora Board of Education Policy (Administering Medication) this form must be completed by the prescribing physician and parent prior to administration of prescription and non prescription medication by designated school personnel. <input checked="" type="checkbox"/> I authorize a designated employee of the Aurora Board of Education to administer the above medication. <input checked="" type="checkbox"/> I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. <input checked="" type="checkbox"/> I understand that additional parent/prescriber statements will be necessary if the dosage or time or interval of the medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> I understand that a parent/guardian is required to drop off medication to the building clinic (unless student self-carries). <input checked="" type="checkbox"/> I understand that Ohio law requires a "back-up" epinephrine autoinjector (if self carries) is available at the designated school health clinic or office for emergencies. {ORC 3313.718(3)}	
Parent must <input checked="" type="checkbox"/> to indicate student is allowed to self-carry their epinephrine autoinjector	
<input type="checkbox"/> I authorize self-medication by my child for the prescribed listed medication	
<input type="checkbox"/> I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician.	
Parent/Guardian signature	Date
#1 contact phone	#2 contact phone
<input type="checkbox"/> Student will meet with school nurse to show they can self carry safely <input type="checkbox"/> If allowed to self administer, student will demonstrate how to properly administer prescribed medication to school nurse	
Student signature	Date