Michigan City Area Schools

Opportunity ★ Excellence ★ Pride

Student Allergy Information

The Michigan City Area Schools does not discriminate on the basis of the Protected Classes of race, color, national origin, sex (including transgender status, sexual orientation and gender identity), disability, age, religion, military status, ancestry, or genetic information, which are classes protected by Federal and/or State law (collectively, "Protected Classes"). This includes the Corporation's employment opportunities, programs, and/or activities, or, if initially occurring off Corporation grounds or outside the Corporation's employment opportunities, programs and activities, affecting the Corporation's environment. For further information, clarification, or complaint, please contact the MCAS School Administration, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Title IX (gender equity related issues); or Special Education Director, 408 S. Carroll Avenue, Michigan City, Indiana 46360 at (219) 873-2000 for Section 504 (non-discrimination/disability issues and Americans with Disabilities). Any other information concerning the above policies may be obtained by contacting the Superintendent, Dr. Wendel McCollum, 408 S. Carroll Ave., Michigan City, Indiana 46360 at (219) 873-2000.

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Administration Building
408 South Carroll Avenue
Michigan City, Indiana 46360
(219) 873-2000

Dear Parent/Guardian:

If you have indicated on the enrollment form that your son or daughter has a severe allergy, it is very important that medication be available at school in the event your child experiences an allergic reaction.

Enclosed is a form for you and your physician to complete to allow for prescription medications to be administered. There is also a form for you to sign authorizing the school to administer non-prescription medication if necessary.

If your child has a **Food Allergy,** you and your physician must complete the Dietary Prescription Form in this packet. The Office of Food Services will work to provide meal substitutions where possible based on the dietary order your physician prescribes.

Completed forms and medication must be turned in to the school

carrying an EpiPen®, completed forms are still required.

We care about your child's health and appreciate your cooperation in keeping your child safe at school.

Sincerely,

Brandi Morlan

Brandi Morlan, BSN, RN
School Nurse Chair

Britney Rodriguez
Director of Nutrition Services

Form # 528
Rev. 7/09

Allergy Action Plan

Place Child's Picture Here

ALLERGY TO: _____

_____ Student's Name _____ Date of Birth _____ Teacher

Asthmatic ❑ Yes* ❑ No *High risk for severe reaction

♦ SIGNS OF AN ALLERGIC REACTION ♦

Systems	**Symptoms**
Mouth	Itching and swelling of the lips, tongue, or mouth
Throat*	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	Shortness of breath, repetitive coughing, and/or wheezing
Heart*	"Thready" pulse, "passing out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

♦ ACTION FOR A MINOR REACTION ♦

1. If only symptom(s) are: _____,

   give _____
   Medication / Dose / Route

Then call:

2. Mother _____, Father _____, or emergency contacts.
3. Dr. _____ at _____.

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

♦ ACTION FOR A MAJOR REACTION ♦

1. **If ingestion is suspected and/or symptoms are:** _____,

   give _____ **IMMEDIATELY!**
   Medication / Dose / Route

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother _____, Father _____, or emergency contacts.
4. Dr. _____ at _____.

DO NOT HESITATE TO CALL 911
Even if Parent / Guardian cannot be reached, do not hesitate to medicate or call 911 to take child to medical facility.

Parent's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

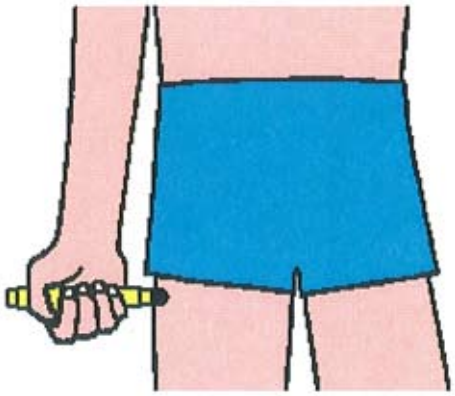
By signing this document I agree to consent to release pertinent medical information and photo of this child to appropriate staff.

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____	1. _____ Room: _____
2. _____ Relation: _____ Phone: _____	2. _____ Room: _____
3. _____ Relation: _____ Phone: _____	3. _____ Room: _____

EPIPEN ® AND EPIPEN ® JR. DIRECTIONS

1. Pull off gray activation cap.

2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. **Hold in place and count to ten.** The EpiPen® unit should then be removed. Massage the injection area for ten seconds.

*****Once EpiPen® has been used, send it to the medical facility with the student.**

For children with multiple allergies, use one form for each allergy.

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Form # 526
Rev. 7/09

Office of Food Services
1100 S. Woodland Ave.
Michigan City, IN 46360
Phone: (219) 873-2131
Fax: (219) 873-2135
www.mcas.k12.in.us

Diet Prescription for Meals at School

Student's Name: _____ School: _____

Age: _____ Grade: _____ Parent/Guardian: _____

Disability: _____ ***OR*** Non-Disabling Medical Condition: _____

Major Life Activity Affected: _____

Diet Prescription (check all that apply):

- ❑ Increased Calories
- ❑ Decreased Calories
- ❑ Diabetic
- ❑ Food Allergy: _____
- ❑ Other: _____
- ❑ Texture Modification
- ❑ Chopped
- ❑ Ground
- ❑ Pureed

Foods to Omit:

_____

_____

_____

Foods to Substitute:

_____

_____

_____

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

_____
Physician/Recognized Medical Authority Signature

Office Phone Number: _____ Date: _____

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Form # 241
Rev. 4/10

AUTHORIZATION TO ADMINISTER PRESCRIPTIVE MEDICATION

PHYSICIAN'S STATEMENT

I have prescribed the medication indicated below for: _____

and do hereby authorize the nurse or principal, or their designee, (i.e. secretary), of

_____ school, to administer the medication as indicated.

Medication: _____

Dosage: _____

The above named student may carry the prescribed **EMERGENCY** medication for

self-administration (circle one) **YES** **NO**

_____ Date

_____ Physician's Signature

_____ Physician's Name (printed)

_____ Physician's Phone Number

PARENT'S AUTHORIZATION

I do hereby authorize the person(s) designated by the above physician to administer this medication for my child, _____, as prescribed above.

I further understand that I will be responsible for supplying this medication to the school in the original pharmacy labeled container.

_____ Date

_____ Parent / Guardian Signature

_____ Telephone

_____ Address

PLEASE NOTE: The Physician's Statement and the Parent's Authorization are valid only for the current school year**. Unless the authorization and statement are renewed, the medication cannot be given to the student.**

TO BE PLACED IN LOCKED STORAGE AREA WITH THE PRESCRIPTION MEDICATION

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Form # 239
Rev. 7/09

PARENTS AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

I do hereby authorize the school principal, teacher or other school employee designated by the principal to administer the non-prescription medication described below to my child, _____ , in the dosage and at the frequency indicated below.

Name of Medication: _____

Dosage: _____

Frequency: _____

I further understand that I will be responsible for supplying this medication to the school in the original labeled container as purchased over the counter to properly identify same.

_____ Date

_____ Parent / Guardian Signature

_____ Telephone

_____ Address

PLEASE NOTE: The Physician's Statement and the Parent's Authorization are valid only for the current school year.

Unless the authorization and statement are renewed, the medication cannot be given to the student.

TO BE PLACED IN LOCKED STORAGE AREA TOGETHER WITH THE NONPRESCRIPTION MEDICATION