Allergy Assessment Form
****TO BE COMPLETED BY THE PARENT(S)****

Our records indicate that your student has a stinging insect allergy (ie bees, wasps, etc). In an effort to better understand the severity of your student's allergy, please answer the following assessment questions and return them to the School Nurse as soon as possible.

Has your healthcare provider informed you that the allergy is life threatening? **YES** **NO**

If YES, please have your healthcare provider complete the ***"Anaphylaxis Emergency Action Plan"*** on the backside of this form, along with any medication authorizations that may apply, and return to the School Nurse as soon as possible.

If NO, please answer the following questions:

My student's reaction to bee/wasp stings can best described as follows. Please check all that apply.

_____ A local reaction at the site of the sting (example: redness, swelling, itching)

_____ A delayed reaction that can occur from two hours to three weeks after the sting. (Symptoms include fever, rash, swelling, and/or joint pain)

_____ Immediately experiences itching, swelling of different body parts (hands, face, neck, etc), hives, shortness of breath, weakness, and/or dizziness

What treatment has your provider recommended in case of a reaction?_____

_____

Does your child require medication at the time of the sting? If so, please list:_____

_____

If a sting occurs at school, students will be given basic first aid. If necessary, the student will be transported via ambulance to the nearest hospital.

PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATIONS INCLUDING EPI PENS AND ANTIHISTAMINES TO THE CLINIC IN A TIMELY MANNER.

Parent signature/Date:_____

School Nurse signature/Date:_____

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: _____ **Age:** _____

Allergies: _____

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

_____

	Symptoms of Anaphylaxis
MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-Injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home_____ **work**_____ **cell**_____

Emergency contact #2: home_____ **work**_____ **cell**_____

Emergency contact #3: home_____ **work**_____ **cell**_____

Comments: _____

_____

_____
Doctor's Signature/Date/Phone Number

_____
Parent's Signature (for individuals under age 18 yrs)/Date

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 ( )

Developed in collaboration with the Ohio Association of School Nurses.

Melanie Queberg RN, BSN

MEDINA COUNTY CAREER CENTER

Authorization for the Administration of Over-The-Counter Medication by School Personnel

Student Name _____ Date of Birth _____

Address _____

Student's Program _____ Student's Instructor _____ Grade _____

PARENT/ GUARDIAN SECTION

We the undersigned request that the specified over-the-counter medication be administered to our child. We understand that the administration of this medication will be done under the supervision of a member of the school staff.

We further understand that the school personnel are not legally obligated to administer medication to any child. Therefore, we agree that the school district and its employees are free from any and all responsibility for the results of such medication or the manner in which it is administered.

We will notify the school immediately if we change or terminate the use of this medication for any reason.

Signature of Parent _____ Date _____

Home Phone Number _____ Work Phone Number _____

Medication must be provided in the original container (bottle). The dosage from the parent cannot exceed the dosage on the label.

Diagnosis for which medication is prescribed _____

Medication _____ Strength _____ Dose _____

Time Medication is to be Taken _____ Administration Start Date _____ Cease Date _____

Instructions or precautions, including possible side effects and storage:

_____

_____

_____

_____