



TWINSBURG CITY SCHOOL DISTRICT

11136 Ravenna Road • Twinsburg OH 44087-1022

Phone: 330.486.2000

Fax: 330.425.7216

Kathryn M. Powers, Superintendent
Martin Aho, Treasurer
Jennifer Farthing, Director of Curriculum

Timothy Sullen, Director of Human Resources
Denise Traphagen, Director of Pupil Services
Andrea Walker, Director of Student Wellness
Chad C. Welker, Director of Business Services

LETTER TO PARENTS ALLERGIC REACTIONS

TO: Parents
FROM: School Health Clinic
DATE: _____
Subject: Allergic Reactions

You have told us that your child can have an allergic reaction.

In an effort to keep your student safe, please provide the following:

1. A completed ALLERGY ACTION PLAN or a similar Emergency Care Plan completed by a licensed prescriber with instructions school staff will follow in the event that your student experiences an allergic reaction while at school.
2. Epinephrine autoinjector(s) if prescribed, and/or other medication to be used if an allergic reaction occurs.

Your prompt attention to this request is appreciated. We would welcome an opportunity to meet with you to discuss your student’s allergy and how we will implement the Allergy Action Plan provided. Please contact me at:

(Please refer to information below regarding permission for your student to self-carry his/her epinephrine autoinjector if authorized by the prescriber.)

Ohio Revised Code (ORC) 3313.718 Possession and use of epinephrine autoinjector to treat anaphylaxis. Effective March 23, 2007, students in Ohio schools will be permitted to carry and use an epinephrine autoinjector with the permission of the prescriber of the medication and the parent/guardian. The law is numbered, Ohio Revised Code (ORC) 3313.718 and applies to any activity, event, or program sponsored by the student’s school or in which the school participates. The Epi-Pen law requires:

- 1) acknowledgment that the prescriber has determined that the student is capable of possessing and using the autoinjector appropriately and has provided the student with training in the proper use of the autoinjector;
- 2) the school has received a backup dose of the anaphylaxis medication; and
- 3) whenever an autoinjector is used, a school employee shall immediately request assistance from an emergency medical service provider (e.g., call 9-1-1).



ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

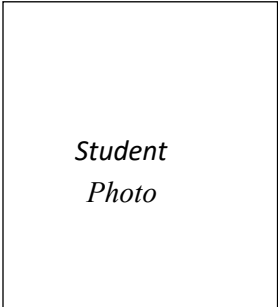
Student _____ School _____

DOB _____ Age _____ Weight _____ Grade/Rm _____

Allergy to _____

START DATE: _____ END DATE: _____

- Student has asthma. Yes No (If yes, higher chance of severe reaction)
- Student has had anaphylaxis. Yes No
- Student may carry epinephrine. Yes No (if yes, complete next page)
- Student may give him/herself medicine. Yes No (If student refuses/is unable to self-treat, an adult must give medicine.)



Student
Photo

IMPORTANT REMINDER

Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

<p>For Severe Allergy and Anaphylaxis</p> <p>What to look for</p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, give epinephrine.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath, wheezing, or coughing <input type="checkbox"/> Skin color is pale or has a bluish color <input type="checkbox"/> Weak pulse <input type="checkbox"/> Fainting or dizziness <input type="checkbox"/> Tight or hoarse throat <input type="checkbox"/> Trouble breathing or swallowing <input type="checkbox"/> Swelling of lips or tongue that bother breathing <input type="checkbox"/> Vomiting or diarrhea (if severe or combined with other symptoms) <input type="checkbox"/> Many hives or redness over body <input type="checkbox"/> Feeling of "doom," confusion, altered consciousness, or agitation <p><input type="checkbox"/> SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____ . Even if child has MILD symptoms after a sting or eating these foods, give epinephrine.</p>	<p>Give epinephrine!</p> <p>What to do</p> <ol style="list-style-type: none"> 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. <ul style="list-style-type: none"> <input type="checkbox"/> Ask for ambulance with epinephrine. <input type="checkbox"/> Tell rescue squad when epinephrine was given. 3. Stay with child and: <ul style="list-style-type: none"> <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. <input type="checkbox"/> Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side. 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine. <ul style="list-style-type: none"> <input type="checkbox"/> Antihistamine <input type="checkbox"/> Inhaler/bronchodilator
<p>For Mild Allergic Reaction</p> <p>What to look for</p> <p>If child has had any mild symptoms, monitor child.</p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Itchy nose, sneezing, itchy mouth <input type="checkbox"/> A few hives <input type="checkbox"/> Mild stomach nausea or discomfort 	<p>Monitor child</p> <p>What to do</p> <p>Stay with child and:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Watch child closely. <input type="checkbox"/> Give antihistamine (if prescribed). <input type="checkbox"/> Call parents and child's doctor. <input type="checkbox"/> If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and

Medication/Doses

Epinephrine autoinjector, intramuscular (list type): _____ Dose: 0.15 mg 0.30 mg

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if student has asthma): _____

Parent/Guardian Authorization Signature	Date	Physician/HCP Authorization Signature	Date
Emergency Contacts/Relationship		Telephone number	
1. _____		_____	
2. _____		_____	
3. _____		_____	

***** (To be completed ONLY if student will be carrying an Epinephrine Autoinjector) *****

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with ORC 3313.718/8313.141)

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.

HEA 4222 3/07