Health forms for students with Allergies

What's in this packet?

Allergy Questionnaire to describe student's allergies – parent to complete.

Release of Information - allows the doctor to talk to the school nurse if there are any questions. Parent to complete.

If the student needs an Epi-pen or similar medicine at school:

- **Guidelines for Medicines at School** - parent reference
- **Epinephrine Auto - injector Medication Authorization:** must be signed by parent and the doctor and brought to school with the Auto - Injector.
- **Medication Authorization** - must be signed by parent and doctor and brought to school with the medication (for medications like Benadryl or Zyrtec.)

Questions - Please call your school nurse: 614-268-8671

Allergy Questionnaire

To be completed by parent

Student:		School Year:
DOB:	Class/Grade:	
Parent:		Cell:
Parent:		Cell:
Emergency Contact:		Phone:
Physician:		Phone:

This information will provide the school nurse with a better understanding of the child's needs. This questionnaire needs updated and completed each school year.

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider? ☐ Yes ☐ No

Note: Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child' **healthcare provider,** school staff will be notified of the allergies and emergency plans.

List all allergies, including foods	Child reacts to allergen if: Circle	Describe allergic reaction:	How long does it take to react?
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		

Prevention: **How does this child prevent and respond to an allergic reaction? (check all that apply)**

☐ The child knows what to avoid
☐ The child asks about ingredients in food, if unsure
☐ The child tells other about his/her allergies
☐ The child will immediately tell an adult if exposed to an allergen
☐ **The child wears an identifying tag or bracelet alerting others to the allergy**
☐ Other:

Allergy Response:

Has this child ever needed to use an epinephrine auto-injector (Epipen): ☐ **Yes** ☐ **No** **If yes, date of last injection:** _____

Are medications needed AT SCHOOL? ☐ **Yes - List** ☐ **No**	**Dose:**	**Time:**
IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.		
Allergy medication AT HOME: ☐ **Yes - List** ☐ **No**	**Dose:**	**Time:**

Any other information or chronic health problems that would be helpful to know?

Date

Parent/Guardian Signature

Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions. The medication cannot be expired.
    - The label must match what is on the Medication Authorization Form.
    - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
    - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

- ***All EXPIRED medication must be picked up by the parent/guardian on the last day of school or it will be discarded.***

AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Bishop Watterson High School.

_____ Obtain Information From: _____

_____

_____

__x___ Release Information To: Bishop Watterson High School
c/o Angela Spangler BSN, RN, LSN.
School Nurse
P- (614) 268-8671 ext. 290
F- (614) 268-0551

___x__ Medical Information/Records –

- immunization record; TB test result/ records
- copy of most recent physical exam on file
- medication authorization to give medication at school
- health appraisals/screenings
- lab work
- psychological information/records
- speech and hearing evaluation
- IEP
- Medical records; healthcare provider notes/summary

_____ Other Information, as specified: _____

_____

_____

This information is to be used by the School Nurse for continuity of care in the school setting.

Date: _____

Parent/Guardian Signature: _____

Electronic signature permitted.

BISHOP WATTERSON HIGH SCHOOL

Epinephrine Auto-Injector Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ HR/Grade _____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs or symptoms _____

Medication_____ Dosage_____ Route_____

Call 911 if medication is administered. Beginning Date _____ Expiration Date_____ or end of school year

Instructions: Inject epinephrine into thigh: _____

If medication does not provide relief or symptoms progress *repeat dose* after _____ minutes. ☐yes ☐no

Precautions and possible side effects to report to the healthcare provider:

_____

Other medications prescribed to this student (home & school) _____

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY:

I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ **Yes** ☐ **No**

The student is capable of possessing and self-administering the auto-injector per ORC 3317.716 and 3313.718. ☐ **Yes** ☐ **No**

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address _____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability and will have the assistance of trained staff as needed.

- If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events: ☐ **Yes** ☐ **No**
  - I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911.
  - I agree to provide the school with backup dose of epinephrine as required by law.

- I understand emergency medical service will be called if the epinephrine auto-injector is used.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school; will notify the school immediately with any changes.
- *I authorize St. James the Less staff to communicate with the student's healthcare provider as needed.*
- I release and agree to hold the Diocese of Columbus, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature **Date**

BISHOP WATTERSON HIGH SCHOOL

Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ HR/Grade _____

Healthcare Provider to Complete:

St. James the Less school urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____ Route_____

Administration Time(s)_____ OR ☐ Every _____ hours as needed for_____

Beginning Date _____ Expiration Date_____ /End of school year

Instructions: _____

_____

Precautions and possible side effects_____

Other medications prescribed to this student (home & school) _____

_____

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.
- I authorize the student named above to receive the medication as ordered above.
- I understand the medication must not be expired, be in the original container and labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- *I authorize St. James the Less school staff to communicate with the student's healthcare provider as needed.*
- I release and agree to hold the Diocese of Columbus, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____