



**BISHOP WATTERSON
HIGH SCHOOL**

Exemplary Catholic Education,
Rooted in Faith, Committed to Excellence

Health forms for students with **Allergies**

Please complete packet and return to the nurse at your child's school.

What is in this packet?

- 1) Parent Letter
- 2) Allergy Questionnaire to describe your child's allergy
- 3) Release of Information - allows the doctor to talk to the school nurse if there are questions
- 4) If the student needs an Epi-pen or similar medicine at school:
 - Guidelines for Medicines at School– parent reference
 - Medication Authorization - must be signed by parent and brought to school with the medication (for medications like Benadryl)
 - Epinephrine Auto-injector Medication Authorization - must be signed by parent and the doctor and brought to school with the Auto-Injector.
- 5) Special Diet Order - if needed – is signed by parent and doctor in case the student has a food allergy that requires a special diet.

Questions - Please call your school nurse.



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**LETTER TO PARENTS
FOOD ALLERGY MANAGEMENT AT SCHOOL**

Dear Parent/Guardian of _____:

Date: _____

Bishop Watterson High School provides nursing services that promote student's ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student's health condition so they are ready to learn.

To help us meet the above goals:

1. The nurse at Bishop Watterson High School is a registered nurse.
2. The school nurse works closely with the student's parents/guardians and their Healthcare Providers to assure access to necessary resources.

In order to assist your student at school and promote effective food allergy management, the following information is required each year. * Please return the included forms to the school nurse upon completion:

- Information for the Food Allergy Action Plan: including medications, current phone numbers and emergency contacts
- Epi-pen and/or anti-histamine Medication Orders from the Healthcare Provider.
- Parent permission forms signed by parent/guardian authorizing for medication and treatment at school.

The parent/guardian is responsible for:

- **notifying the school about any food allergies**
- **teaching the student about foods to avoid**
- **teaching the student about what to do if the student is exposed to the allergen**
- **teaching the student to recognize and report the symptoms of anaphylaxis to an adult**
- **provide the school with appropriate medical authorization and medication**

We are looking forward to helping your child with a food allergy be successful in school. Please feel free to contact me with any questions or concerns.

Your student's School Nurse is: _____ Tonya Friend, RN, BSN _____

Phone number: _____ 614-268-8671 ext.290 _____ Days at school: _____ Monday-Friday _____



Allergy Questionnaire

To be completed by parent

Student Name _____ Date of Birth _____ School Year _____
 School _____ HR/Grade _____
 Parent/Guardian _____ Relationship _____ Phone _____
 Parent/Guardian _____ Relationship _____ Phone _____
 Emergency Contact _____ Relationship _____ Phone _____
 Healthcare Provider _____ Phone _____ Fax _____

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's healthcare provider, school staff will be notified of the allergies and emergency plans.

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

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

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? <input type="checkbox"/> Yes - List <input type="checkbox"/> No	Dose:	Time:
<i>IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.</i>		

Allergy medication AT HOME: <input type="checkbox"/> Yes - List <input type="checkbox"/> No	Dose:	Time:

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

Parent/Guardian Signature _____ Date: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Date:

Student Name:		Birth Date:	
School Name:		School Phone:	
Requested by: (BWHS Staff)		School Fax:	

In order to release any confidential information regarding your student, Bishop Watterson High School is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals at Bishop Watterson High School may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school. *Please indicate the name, address and phone number of the providers that BWHS may request from or send information to. Make sure to un-check any information you do NOT wish to be shared.*

OK to Request data	Ok to Send data	Provider Name	Provider Address	Provider Phone

I understand the requested information below will be used by the Bishop Watterson staff for educational and health care planning and service delivery: **Please un-check any information you do NOT wish to be shared.*

<input type="checkbox"/> Medical Information/Records	<input type="checkbox"/> Psychological Information/Records	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> TB Test Results/Records	<input type="checkbox"/> Speech and/or Hearing Evaluation	<input type="checkbox"/> School Health Records
<input type="checkbox"/> Other information, as specified:		

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987).

Authorization for Redisclosure: Under federal law, BWHS may not redisclose the information identified above to any other party without prior consent.

Parent/Guardian or Adult Student Signature

Date

Printed Name of Parent/Guardian or Adult Student



Guidelines for Prescription Medications at School

Students needing to take prescription 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 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 unused medication must be picked up by the parent/guardian on the last day of school or it will be discarded.***



Medication Authorization

ONE FORM PER MEDICATION

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

Healthcare Provider to Complete:

Bishop Watterson High School urges scheduling doses for times outside of school.

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

Medication _____ Strength/Concentration _____ 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 Number** _____

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 Bishop Watterson Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold The Diocese of Columbus, the Board of Education, 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 _____



Epinephrine Auto-Injector Medication Authorization

ONE FORM PER MEDICATION

Student Name _____ Date of Birth _____ School Year _____
Home Address _____ School _____ 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 _____ **Strength/Concentration** _____ **Dosage** _____

Route _____ **Beginning Date** _____ **Expiration Date** _____ or end of school year

CALL 911 when medication is administered. Repeat dose if medication does not produce relief yes no

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

Per state law, I prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. yes no

Healthcare Provider Signature _____ **Date** _____

Provider Name _____ *Please fill contact information to left or stamp here*

Practice Address _____

Phone _____ Fax _____

Phone _____ Fax _____

Parent to Complete:

Parent/Guardian Name _____ **Phone Number** _____

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 Bishop Watterson Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Diocese of Columbus, the Board of Education, 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** _____