The following forms (Asthma Action Plan, Allergy Action Plan and Administration of Medication) need only be completed if they pertain to your child. If your child has a severe allergy, asthma or requires routine medication, please complete and return. We cannot give medication to your child without the appropriate forms that contain the parent and physician signatures.

All medication must be in an original container with your child's name on it.

****Please note that all three of these forms require a doctor's signature. ****

St. Teresa of Avila School
1194 Rulison Avenue
Cincinnati, OH 45238
Phone: 471-4530 Fax: 471-1254

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

_____ is under my care and should receive

_____ at the following times _____
Name of drug, dosage, route

Specific instructions for administration: _____

Possible side effects to watch for: _____

Expiration date of this request: _____

Date: _____ Physician's Signature: _____

Physician's Phone Number: _____

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his/her delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of Student: _____

Name of Medication: _____ Dosage/Route: _____

at the following time(s): _____

Date: _____ Signature of Parent/Guardian: _____

ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student _____

DOB _____ Teacher _____

Allergy to _____

Asthmatic? ☐ Yes* ☐ No *Higher risk for severe reaction

STEP 1 - TREATMENT

SEND STUDENT TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

The severity of symptoms can quickly change. †Potentially life threatening

Symptoms		Give checked Medication**	
		***To be determined by physician authorizing treatment*	
◊	If a student has been exposed to/ingested an allergen but has NO symptoms:	☐ Epinephrine	☐ Antihistamine
◊ Mouth	Itching, tingling, or swelling of lips, tongue, mouth:	☐ Epinephrine	☐ Antihistamine
◊ Skin	Hives, itchy rash, swelling of the face or extremities:	☐ Epinephrine	☐ Antihistamine
◊ Gut	Nausea, abdominal cramps, vomiting, diarrhea:	☐ Epinephrine	☐ Antihistamine
◊ Throat†	Tightening of throat, hoarseness, hacking cough:	☐ Epinephrine	☐ Antihistamine
◊ Lung†	Shortness of breath, repetitive coughing, wheezing:	☐ Epinephrine	☐ Antihistamine
◊ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine	☐ Antihistamine
◊ Other*	_____	☐ Epinephrine	☐ Antihistamine
◊	If reaction is progressing, (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

DOSAGE START DATE _____ END DATE _____

Epinephrine: Inject intramuscularly.

☐ EpiPen® ☐ Other _____ _____

☐ EpiPen® Jr. Medication/Dose

☐ Auvi-Q 0.3mg

☐ Auvi-Q 0.15mg

Important: *Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.*

Antihistamine: Give _____

antihistamine/dose/route

Other: Give _____

medication/dose/route

STEP 2 - EMERGENCY CALLS

PARAMEDICS (911) MUST BE CALLED IF EPIPEN OR AUVI-Q IS GIVEN. EPIPEN OR AUVI-Q ONLY LAST 15-20 MINUTES.

1. Call 911. State that an anaphylactic reaction has been treated, type of treatment given (i.e., EpiPen or Auvi-Q) and that additional epinephrine may be needed. Always send empty autoinjector to ER with student.

EMERGENCY CONTACTS

	NAME	RELATIONSHIP	TELEPHONE NUMBER
1.			
2.			

EVEN IF PARENT/GUARDIAN IS UNAVAILABLE, DO NOT HESITATE TO MEDICATE CHILD & CALL 911

*****SIGNATURE OF PARENT/GUARDIAN & PHYSICIAN REQUIRED ON NEXT PAGE*****

Prescriber Name _____ Phone number _____

Prescriber Signature _____ Date _____

******(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

ASTHMA ACTION PLAN

Student Information:

Student: _____ Birthdate: _____

Grade: ___ Homeroom Teacher or Class: _____

Physical Education Days and Times: _____

Emergency Information:

Parent(s) or Guardian(s) _____

Mother: Tel (W) _____ Tel (H) _____

Father: Tel (W) _____ Tel (H) _____

Healthcare Provider _____ Tel _____

In case of emergency, contact:

1. Name _____ Tel _____
2. Name _____ Tel _____

Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: _____

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

Signature of Parent/Guardian _____ **Date** _____

Signature of Prescriber _____ **Date** _____

PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER (over)