St. Mary School-Delaware

Sally Selmek R.N.-School Nurse

Dear Parents,

The Diocese of Columbus has recently introduced a policy (policy 5141.35) for life-threatening food allergies in order to provide a safe environment for student. Parents should notify the school nurse and homeroom teacher of any life-threatening food allergy on or before the first of each school year or as soon as a food allergy is diagnosed.

Each school year, parents and physicians will be required to complete, sign and return a "Food Allergy Action Plan" specific to the student with life-threatening food allergies. I will review all allergy information provided by the parents and physician and share this information with the appropriate teachers and staff.

It's your responsibility as parents to provide the school with the medication prescribed in the "Food Allergy Action Plan". Medication will be kept in the nurse's office.

The parents of a student with a life-threatening food allergy will provide a supply of "safe" snacks for use by their child. Parents of children with life-threatening food allergies are responsible for notifying bus transportation providers with information regarding their child's allergy.

I'm sorry for the inconvience of more paper work and the requirement involving the physician's signature, but this is necessary in order to keep your child safe. Please complete the form attached and return it as soon as possible.

Thank you for your cooperation.

Sally Selmek R.N. – School Nurse

St. Mary School – Delaware

Physician's request for the Administration of Medication by school personnel

Student Name _____ Date of Birth _____

School _____ Grade _____

Parent Section

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1.This form must be completed by both the parent (top section) and physician (bottom section).

2.Medication must be kept in the student's prescription labeled bottle. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instruction from doctor. If it is a non-prescription drug, it must be in the original container.

3. A revised statement signed by the physician must be provided when there is a change in the dosage to be given and a new form provided each school year.

When possible, give medication outside of school hours. For example, to be able to administer four (4) doses to the child, it might be given before school, immediately after school, before child's bedtime and before parents' bedtime. Please contact the school nurse if you have questions.

Signature of Parent _____ Date _____

Physician Section

I, the undersigned physician am certifying that medication for the student listed below cannot be scheduled for other than school hours. Further, I realize that medically untrained personnel may supervise the administration of such medication.

I verify that this medication must be taken by _____
Name of Student

Name of Medication_____ Dosage to be Administered_____ # of pills supplied _____

Any severe adverse reactions, which should be reported to the doctor _____

Special instructions for administering the medication, including storage requirements or sterile Conditions _____

Time medication Is to be taken _____ Prescription start date _____ Expiration Date _____

Physician's Signature _____ Date _____

Physician's printed name _____ Phone _____

St. Mary School – Delaware
Sally Selmek RN – School Nurse
NUTS/ PEANUTS

Dear Parents,

According to the Emergency Medical form recently completed on your child/children, there is an allergy regarding "nuts", or "peanuts". This is important that we make sure your child/children are safe while they are here at St. Mary School; therefore a NO NUTS/PEANUT table is available for the students during lunch. These students may have friends sit with them at this table as long as their friends do NOT have nut or peanuts products in their lunch.

Please complete this form and return it to the office.

_____I want my child _____, to sit at the "Nut Free" table.

_____I DO NOT want my child_____,to sit at the "Nut Free" table, and I accept the risks (possible allergic reaction) involved with this decision.

Sign + Date X _____

Thank You,
ASelmek RN
Sally Selmek RN, BSN
School Nurse

5141.35

☐ ELEMENTARY
☐ SECONDARY
■ BOTH

☐ POLICY
■ REGULATION

STUDENTS

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

ALLERGY TO:_____

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

Place Child's Picture Here

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪ If a food allergen has been ingested, but *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†	Weak or 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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent_____ Phone Number(s) _____
4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a._____	1.)_____	2.)_____
b._____	1.)_____	2.)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Cont'd.

STUDENTS

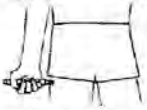
TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- **Remove caps labeled "1" and "2."**
- **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.**
- **Slide yellow collar off plunger.**
- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

June/2007