ALLERGY ACTION PLAN

USE 1 FORM PER CHILD FOR EACH ALLERGEN

Student Photo

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.)

IMPORTANT REMINDER

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

For Severe Allergy and Anaphylaxis **What to look for** If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**. ☐ Shortness of breath, wheezing, or coughing ☐ Skin color is pale or has a bluish color ☐ Weak pulse ☐ Fainting or dizziness ☐ Tight or hoarse throat ☐ Trouble breathing or swallowing ☐ Swelling of lips or tongue that bother breathing ☐ Vomiting or diarrhea (if severe or combined with other symptoms) ☐ Many hives or redness over body ☐ Feeling of "doom," confusion, altered consciousness, or agitation ❑ ***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.***	**Give epinephrine!** **What to do** 1. Inject epinephrine right away! Note time when epinephrine was given. 2. Call 911. ☐ Ask for ambulance with epinephrine. ☐ Tell rescue squad when epinephrine was given. 3. Stay with child and: ☐ Call parents and child's doctor. ☐ Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes. ☐ 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. ☐ Antihistamine ☐ Inhaler/bronchodilator
For Mild Allergic Reaction **What to look for** If child has had any mild symptoms, **monitor child.** Symptoms may include: ☐ Itchy nose, sneezing, itchy mouth ☐ A few hives ☐ Mild stomach nausea or discomfort	**Monitor child** **What to do** Stay with child and: ☐ Watch child closely. ☐ Give antihistamine (if prescribed). ☐ Call parents and child's doctor. ☐ If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis")

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

I received a copy of the 504 Procedural Safeguards for the current school year. _____
Parent/Guardian Signature

SECTION 504 PARENT/CHILD RIGHTS AND PROCEDURAL SAFEGUARDS

1. Your child has a right to take part in and receive benefits from public education programs without discrimination based on a disability.
2. You have the right to receive written notice prior to any action by the district in regard to the identification, evaluation, or placement of your child.
3. Your child has a right to an evaluation prior to the development of an initial § 504 plan and any subsequent significant change in placement. Your child is eligible for a free appropriate public education under § 504 of The Rehabilitation Act of 1973 if the § 504 Team determines that your child has a physical or mental impairment that substantially limits one or more major life activities, including the provision of regular or special education and related aids and services that are designed to meet the individual educational needs of the student as adequately as the needs of students without disabilities are met and that are based upon adherence to Section 504's procedural requirements. Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, communicating, working, and learning, or the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, or endocrine functions.
4. The district shall consider information from a variety of sources, including (as appropriate) but not limited to aptitude and achievement tests, teacher recommendations, physical condition, social and cultural background, adaptive behavior, medical reports, student grades, progress reports, parent observations, anecdotal reports, and test scores when making eligibility, educational, and placement decisions under § 504.
5. Eligibility decisions must be made by a group of persons knowledgeable about your child, the meaning of the evaluation data, and the placement options.
6. If eligible as disabled under § 504, your child has a right to periodic reevaluations, generally every three years, before your child's placement is terminated or significantly changed, and if otherwise determined to be necessary.
7. Your child has the right to a free appropriate public education ("FAPE"), meaning the provision of education and related services without cost to the person with a disability or his or her parents or guardians except for those fees that are imposed equally on non-disabled students or their parents.
8. Your child has a right to access facilities, services, and activities that are comparable to those provided for non-disabled students.
9. You have the right to examine educational records of your child and obtain copies at a reasonable cost.
10. With respect to actions regarding the identification, evaluation, or educational placement of your child under Section 504, you have the right to notice, an opportunity to examine relevant records, an impartial hearing with opportunity for participation by you and representation by counsel, and a review procedure.
11. If you wish to challenge the actions of the district's § 504 Team in regard to your child's identification, evaluation, or educational placement, you should file a written grievance with the district's § 504 Compliance Officer, Tebra Page, at Solon City School District, 33800 Inwood Road, Solon, Ohio 44139, within 10 calendar days from the time you received written notice of the § 504 Team's action(s). A hearing will be scheduled before an impartial hearing officer selected and appointed by the district and you will be notified in writing of the date, time, and place for the hearing.
12. If you disagree with the decision of the impartial hearing officer appointed by the district, you have a right to a review of that decision by a court of competent jurisdiction.
13. You have a right to file a complaint with the United States Department of Education Office for Civil Rights (OCR) at any time. OCR may be contacted at 600 Superior Avenue, East, Suite 750, Cleveland, Ohio 44114-2611.

Cari Root Name	Director of Pupil Personnel Title
33800 Inwood Road Address	(440) 349-6258 Telephone
Solon, Ohio 44139 City, State, and Zip	cariroot@solonboe.org E-mail
Solon City School District	