Dear Parent(s),

Because each child with allergies presents a little differently and responds to different interventions, I would like to know from you how to prevent and respond to an allergic reaction, specific to your child. This packet includes required forms to assist me in this endeavor.

- **The Allergy Action Plan**- This form is for me, and necessary staff, to use if your child is exposed to an allergen. This form will be sent with LCA staff members on field trips. A physician signature is required.

- **The Allergy IHP**- The information documented on this form will assist us in deciding on any accommodations, if needed, to the classroom environment, and class parties. This form does not require a physician signature.

- **Medication form**- This form is for non-prescription and prescription medications and must be completed in its entirety. Each medication, and child, requires a separate form; I cannot have multiple medications, or student names, listed on one form. All medication is to be stored in the clinic. Medications must be unexpired, unopened, and in the original container; and have a pharmacy label if it's a prescription medication. Please remember that all prescription medications must have a physician signature on the medication form. The clinic will not accept any medication unless accompanied with this completed form, and with the appropriate signatures.

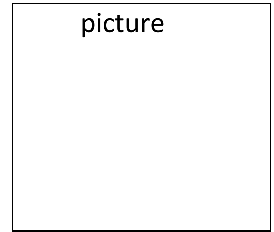
- **Self-Carried Medication** applies only to emergency medications and is limited to JH and HS. Please note that according to ORC 3313.718, you are required to give the clinic a backup EpiPen if you choose to allow your child to self-carry one.

Please have this paperwork completed over the summer, as it can take several weeks for physicians to complete them and prepare any required prescriptions. If you have any questions, please contact me

Jamie Hartsell, RN, BSN
School Nurse
1101 Wesley Ave.
Xenia, OH 45385
937- 352-1655 (ph)
937-352-1641 (fax)
nurse@legacyknights.org

Individualized Health Care Plan

Allergic Reaction



Name of Student:____

Grade:_________ **Homeroom:**__________ **Bus Rider:** ☐ **yes** ☐ **no Bus #**_____

Allergy to:____

Asthmatic: ☐ **Yes** ☐ **No** *** HIGH RISH FOR SEVERE REACTION**

<u>Accommodations needed for classroom or school environment:</u>

____General Letter sent to parents of students in that grade.

____Sign for specific allergy-free environment outside classroom.

<u>In the event of classroom/school parties, food treats will be handled as follows:</u>

____ Student may eat the treat

____ Student may take the treat home

____ Replace treat with parent supplied alternative

____ Modify treat as follows:____

Additional Instructions:____

____

____

Student has an Emergency Action Plan: ☐ **Yes** ☐ **No**

The school nurse has consent to share this Information with the appropriate staff and food service personnel on a need to know basis. ☐ **Yes** ☐ **No**

Parent/Guardian Signature:__________________________________ Date:_____________

School Nurse Signature:______________________________________ ______________________

The following staff members have been trained in the administration of EpiPens:

to be completed by school nurse

____________________________ ______________________________

____________________________ ______________________________

Any revision to the student's IHP/EAP requires a new form to completed and dated by the parent.

Legacy Christian Academy
School Medication Administration Authorization Form
Prescription or Non-Prescription Medication

Legacy Christian Academy Clinic
1101 Wesley Ave., Xenia OH 45385
Phone: 937-352-1655
Fax: 937-352-1641

Student's Name: * Only one student name per form*		Grade:
Address:		Phone
City:	State:	Zip:

Medication Name: *Only list one medication per form*	**Dosage:**
Time/Frequency of administration:	**Special instructions for administration or storage:**
Date administration is to begin:	**Date to cease:**
Severe adverse reactions that should be reported to the physician:	

Required for prescription medications only		
Physician's name and address:		
One or more of physician's phone number:		
Phone:	**Phone:**	**Fax:**
Physician's signature:		**Date:**

This form must be completed entirely in order for medication to be administered.

All medications must be in the original container with label intact.

All prescription medications need to have the dosing information completed and signed by a physician.

Any changes to prescription medication dosage or administration need to be signed by a physician.

Emergency Medication Self Carry/Administration Authorization/Approval

Self carry/administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State Medication Policy.

Prescriber authorization for self carry/administration of emergency medication:____________________________

School Nurse approval for self carry/self administration of emergency medication: ________________________

Parent/Guardian Authorization

I/We request designated school personnel to administer the prescription medication as prescribed by the above prescriber. I/We request the designated school personnel or volunteer nurse to administer the non-prescription medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We authorize the school nurse to communicate with the health care provider if needed.

Parent/Guardian Signature____Date:___________________

Home Phone #:___________________Cell Phone #___________________Work Phone #__________________