# Allergy Packet

## ** New forms are required at the beginning of every school year.

Please note:

- The Allergy Questionaire form is for the parent to complete to help us better understand your child's allergy history
- The Food-Allergy Action Plan for your child's doctor to Complete and parent sign
- If your child is going to self-carry their emergency epinephrine and/or inhaler, you both must complete and sign the self-carry portion on the second page of the AUTHORIZATION FOR ADMINISTRATION OF MEDICATION form.

# Allergy Questionnaire

**Student Name_____ DOB_____**

**School_____ Grade_____**

You indicated during registration that your child has an allergy. Please provide us with additional information about your child's health needs by responding to the following questions.

Primary Healthcare Provider:_____ Phone:_____

Allergist:_____ Phone:_____

1. **Does your child have a diagnosis of an allergy from a health care provider: □ No □Yes**
2. **Please indicate what your child is allergic to by checking the appropriate box:**

**□ Peanuts □ Tree Nuts □ Milk □ Latex □ Bee Sting □ Other_____**

3. **Age of student when allergy first discovered: _____**
4. **When was your child's last allergic reaction?_____**
5. **Please indicate or describe the type of allergic reaction your child has had in the past:**

**□ Anaphylactic Reaction ( □ Epinephrine Given □ Benadryl given)**
**□ Itching, tingling or swelling of the lips, tongue, mouth**
**□ Hives, itchy rash**
**□ swelling of the face or extremities**
**□ Nausea, abdominal cramps, vomiting, diarrhea**
**□ Tightening of the throat, hoarseness, hacking cough**
**□ Shortness of breath, repetitive coughing or clearing of the throat, wheezing**
**□ Fainting, pale or blue color to the lips and/or skin**
**□ Other, please describe:(Please include things your child may say)_____**
**_____**

**6. Please indicate when your child reacts to the allergen by checking all that apply.**
**□ Eats the allergen □ Touches the allergen □ Inhales the allergen □ Stung by the allergen**
**□ Other, please describe:_____**
**7. How have past reactions been treated?_____**
**8. How effective was your child's response to treatment?_____**
**9. Do you have prescription medication to treat the allergy? □ Yes □ No**
**10. Have you used the treatment or medication? □ Yes □ No**
**Please describe any side effects your child had to the medication:_____**
**11. Is your child aware of their allergies and what they need to avoid? □ Yes □ No**
**12. Does your child know how to use their emergency medication? □ Yes □ No**
**13. How might your child's allergic condition impact school performance or participation in school activities?_____**

**Parent/ Guardian Signature_____ Date:_____**

**Reviewed by R.N._____ Date:_____**

# ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

**NAME:**_____ **D.O.B:**____/____/____

**TEACHER**:_____ **GRADE:**_____

**ALLERGY TO**:_____

**Asthma:** ◯ Yes (higher risk for a severe reaction) ◯ No

Weight: _____ lbs

**ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:**

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

## INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

*Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.*

**When in doubt, use epinephrine. Symptoms can rapidly become more severe.**

**MILD SYMPTOMS ONLY**

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

## GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

**IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE**

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

**MEDICATIONS/DOSES**

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

**MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.**

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

**CONTACTS: Call 911 Rescue squad: (_____)_____**

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

**Licensed Healthcare Provider Signature:**_____ Phone:_____ Date:_____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

**Parent/Guardian Signature:**_____ Date:_____

**DOCUMENTATION**

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

**TRAINED STAFF MEMBERS**

Name:_____ Room:_____

Name:_____ Room:_____

Name:_____ Room:_____

**LOCATION OF MEDICATION**

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: _____

**ADDITIONAL RESOURCES**

**American Academy of Allergy, Asthma and Immunology (AAAAI)**
414-272-6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

**Children's Memorial Hospital**
773-KIDS-DOC
http://www.childrensmemorial.org

**Food Allergy Initiative (FAI)**
212-207-1974
http://www.faiusa.org

**Food Allergy and Anaphylaxis Network (FAAN)**
800-929-4040
http://www.foodallergy.org

**This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.**

Print Reset Form

**GLENVIEW SCHOOL DISTRICT 34**
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

**ENGLISH** **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

Parent or Guardian:
Both pages of this form must be completed prior to the administration of any medication in accordance with district policy and guidance from the Illinois State Board of Education.
All medications provided to the school must be:

- In their **original prescription container,** labeled with the name of the student, prescribing physician, name of medication, dosage, route, time to be given and name of pharmacy **OR**
- In the **original manufacturer's package**, if non-prescription medication.
- The parent/guardian or other responsible **adult should bring any medication to the school health office**.
- Medication **cannot** be expired.

**Student's Name:**_____**Date of Birth:** _____

**To Be Completed by the Physician:**

Only medication which is prescribed by a physician and which are absolutely necessary for the critical health and well being of the student shall be given. Please indicate whether this medication must be taken during the school day. **Yes** ☐ **No** ☐

**Medication:** _____ **Dosage:** _____

**Route:**_____ **Frequency:**_____ **Scheduled** ☐ **PRN** ☐

**Additional Specific Instructions:** _____

**Diagnosis/ Indication / Intended Effect:**_____

**Possible Side Effects:** _____

**Other Medication(s) Student is taking:** _____

**Duration of Order:** **Current School Year** **or other: (specify duration)** _____

**Emergency Medications**: Epinephrine or Inhaler: (MD/PA/NP must initial below):

_____**Student may self-carry/ self-administer their emergency medication.**
I have instructed the student on the administration of this medication and find that they are able to administer this medication independently. (It is recommended that "back-up" medication be stored in the school health office).

**Licensed Prescriber:**

**Prescriber name:** _____ **Phone Number:** _____
(printed)

**Signature:** _____ **Date of Order:** _____

**GLENVIEW SCHOOL DISTRICT 34**
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

**Parent/ Guardian Authorization for School Medication**

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Glenview School District 34 and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, albuterol or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction, asthma attack or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff 1-1-19. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a certificated and registered school nurse, and I specifically consent to such practices, and.

I agree to indemnify and hold harmless District 34, members and its employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.
In the event an epinephrine auto-injector is administered to my child, I acknowledge and understand that the school district personnel will call 9-1-1 to alert emergency services.

I agree to notify the school of any changes in medication for my child's condition.

I understand that I will need to pick up any unused doses of the medication at the end of the school year. Unused medications will not be sent home with my child and will be destroyed if not picked up by the last day of school.

Parent/ Guardian Signature: _____ Date: _____

Guardian Phone Number(s): _____

**Parent/ Guardian Agreement Authorizing Self Carry/ Self Administration of Asthma Medication or Epinephrine Auto Injector**
**Before your child will be allowed to self-carry/ self-administer medication, we must ask you to sign below:**

I agree with the provider statement above, and therefore authorize Glenview District 34 and its employees and agents, to allow my child to self-carry and/or self-administer the above named medication (1) at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) during before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/ guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff. 1-1-19)

The permission for self-administration of medication is effective for the school year in which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. We recommend that you provide an additional dose of the medication to be kept at the school in the event that your child forgets or loses his/her medication.

*Your signature below indicates receipt of the above information as well as authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.*

Parent/Guardian Signature: _____ Date_____

Witness:_____ Date_____

**The student must complete the following section (for self-carry):**
I agree to:

1. Demonstrate correct use of the inhaler or epinephrine auto-injector using a trainer to the school health office staff
2. Never share my medication with another person
3. Notify a responsible adult if there is no improvement in my breathing after using my inhaler **OR**
4. Immediately notify a responsible adult if I use my epinephrine auto-injector.

Student Signature_____ Date _____