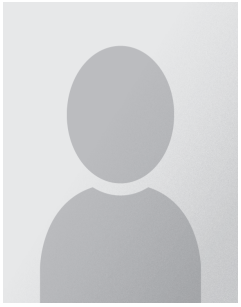
Northbrook School District 27 - School Year 2022-2023
ALLERGY EMERGENCY ACTION PLAN



Name: **D.O.B.:**

Grade: **School:**

Allergy to:

Asthma: ☐YES (Higher risk for a severe reaction) ☐NO

Must sit at nut-free table: ☐YES ☐NO

Any SEVERE SYMPTOMS after suspected or known ingestions
One or more of the following:

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

Or **combination** of symptoms from different body areas:

SKIN	Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT	Vomiting, diarrhea, cramping abdominal pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring **(see box below)**
- Give 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

GIVE ANTIHISTAMINES
Stay with child, alert health care professionals and parents. **If symptoms progress (See Above), INJECT EPINEPHRINE**

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 recut. For a severe reaction, consider keeping the child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ By checking this box, I give permission to give epinephrine for ANY symptoms if the allergen was likely eaten.

☐ By checking this box, I give permission to give epinephrine before symptoms if the allergen was definitely eaten.

☐ By checking this box, I authorize my student to self-carry epinephrine.

☐ By checking this box, I authorize my student to self-administer epinephrine.

MEDICATIONS/DOSES

EPINEPHRINE (Brand, dose, route): _____

ANTIHISTAMINE (Brand, dose, route, frequency): _____

Other (e.g. inhaler: brand, dose, route, frequency): _____

CONTACTS: CALL 911

Parent/Guardian: _____ **Phone Number:** _____

Parent/Guardian: _____ **Phone Number:** _____

Other Name: _____ **Relationship:** _____ **Phone Number:** _____

Licensed Healthcare Provider Signature: _____ **Date:** _____

Please Print Healthcare Provider's Name: _____ **Date:** _____

I hereby authorize Northbrook School District 27 staff members to take whatever action in their judgement 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:** _____

Location of Medication: ☐ Student to carry ☐ Health Office ☐ Classroom ☐ Other: _____