Health Office
7401 Clarendon Hills Road
Darien, Il 60561
Ph: 630-468-4595   Fax: 630-468-4615

Dear Parent/Guardian:

Your student's health records indicate an allergy to bee stings, food, or other substances. If your physician recommends the administration of an Auto-Injector or Benadryl, please complete the attached Student Allergy/Anaphylaxis Emergency Treatment Plan. This additional information will allow Health Services to effectively respond to your child's allergic condition.

Review the plan carefully with your child's physician and please provide the required signatures. If an Auto-Injector/Epi-Pen is needed, your student may carry one with the physician's approval. However, your student may store an additional Epi-Pen in the Health Office. If your student has Benadryl noted for allergy intervention, then please send the medication to be kept in the Health Office, along with the Medication Authorization Form.

If your student's health record indicates a health condition of asthma then please note the inhaler on the Medication Administration Form with the physician's signature. Illinois State Board of Education requires that an Asthma Action Plan is kept on file in the Health Office. Please see attached forms necessary.

Return completed forms to the Health Office. Required forms include:

1. Illinois food and allergy emergency action plan and treatment authorization
2. Medication Authorization Form
3. Asthma Action Plan (if applicable)

Your student can also leave a spare inhaler in the Health Office for your child's use.
Send Forms to:

Southhealth@hinsdale86.org

In good health,

Karen Fitzer, RN and Mary Baumbach, RN

ILLINOIS FOOD AND OTHER ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Student Name: ________________________________ Date of Birth: ____________________
Phone Number: ________________________________ ID#: __________________________
Health Care Provider: ___________________________ Weight: _________________________

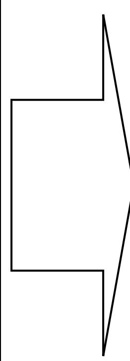
History of Asthma: ☐ **No** ☐ **Yes (Higher risk for severe reaction)**

ALLERGY: (check appropriate) **TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY**

☐ **Foods** (list):____
☐ **Medications** (list):____
☐ **Latex:** Circle one: Type I (anaphylaxis) Type IV (contact dermatitis)
☐ **Stinging Insects** (list type):_________________________________
☐ **Other** (list):____

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

Lung++ Shortness of breath, wheeze, repetitive cough
Heart: ++ Pale, blue faint, weak plus, 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, cramps



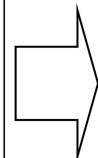
INJECT EPINEPHRINE IMMEDIATELY IN LATERAL THIGH

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

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

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/fact, 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.

DOSAGE: TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY

- **EPINEPHRINE:** Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
- **ANTIHISTAMINE:** Diphenhydramine (Benadryl®) ____ mg (Liquid or Fastmelts). ONLY if able to swallow.
- **OTHER:** e.g. inhaler-bronchodilator________________________________

☐ This child has received instruction in the proper use of:
Circle One - Auto Injector - EpiPen® - Auvi-Q®. It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry the auto-injector.

Health Care Provider Signature:____________________________ Phone:____________ Date: _________

EMERGENCY PROTOCOL

1. **Call 911. Stay with the child. State that an allergic reaction has been treated. Note the time of the injection. Circle the location of the injection site with a permanent marker.**
2. **A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur.**
3. **Treat for shock. For a severe reaction, consider keeping child lying on back with legs raised prepare to do CPR.**
4. **Call parent/guardian to notify of reaction, treatment and student's health status.**

OVER---→

Side 2 – To be completed by Parent/Guardian

Student Name:_________________________________ **Date of Birth:**_______________

Parent/Guardian Authorizations:

- ☐ **I want my child to carry an auto-injector.**
- ☐ **I do NOT want my child to self-administer epinephrine**.

EMERGENCY CONTACTS:

	NAME	HOME PHONE	WORK PHONE	CELL PHONE
Parent/Guardian				
Parent/Guardian				
Other:				

I understand that submission of this form may require the Nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication. My signature below provides authorization of this contact.

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. The school district or nonpublic school and its employees and agents, including a physician providing standing protocol or prescription for school epinephrine auto-injectors, are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse. 105 ILCS 22-30(c)

Prior to any off-campus activity, a parent must give advance notice to the field trip sponsor or coach regarding their student's special health needs.

In addition to the emergency medication in Health Services, the student should carry an extra set at all times.

Students must carry an extra set of emergency medication (EpiPen, antihistamine, inhaler, etc.) to all extracurricular activities such as athletic practices and games, fieldtrips and club events.

Students are responsible to inform **their coach, field trip sponsor or club sponsor of the medications exact location i.e. sport bag on the field, fanny pack, etc**.

Parent/Guardian Signature: ____Date:_______________

Student Signature: ____ Date:_______________

LOCATION OF MEDICATION:

- ☐ Student to carry
- ☐ Health Office / Designated Area for Medication
- ☐ Other: ____

Rev 6/4/2015 Form adapted from Illinois Food Allergy Emergency Action Plan, Emergency Epinephrine Act PA 97-0361 Physician's Toolkit and Asthma and Allergy Foundation of America, Alaska Chapter

HINSDALE SOUTH HIGH SCHOOL

MEDICATION AUTHORIZATION FORM

HINSDALE SOUTH HIGH SCHOOL
HEALTH OFFICE
PHONE: 630-468-4595 FAX: 630-468-4615
southhealth@hinsdale86.org

Student Name: _____________________**ID**:______________ **DOB**: ________________

TO BE COMPLETED BY THE PHYSICIAN: (please print)
All medication requires authorization each school year. It is the parent's responsibility to update student health information in the event of any change.
Medication Required during School Dosage/Time/Frequency Diagnosis/Intended effect

1.____

2.____

3.____

Physician's Signature:__________________________**Phone:**___________________**Fax:**______________

SELF MEDICATION ONLY
Medication students may carry and self-administer: Inhaler, Insulin, or Epi-Pen (circle if applicable). If a student will be utilizing insulin or an epi-pen the corresponding action plan must be completed by the physician and parent. For students that self-carry an Inhaler, attach a copy of the medication label and provide a parent's signature at the bottom of this form. The appropriate (asthma, diabetic, allergy, and anaphylaxis) action plan(s) can be downloaded from our website. Please contact the school nurse at630- 468-4595 if you have any questions or concerns.
Self-Administered Medication: such as medication for diabetes, severe allergy, or other specified condition: I or a member of my staff has instructed the above student in the proper administration of the self-administered medication. He/she understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side effects or lack of appropriate response. The student is capable of using this medication independently.

Physician's Signature: _______________________ **Phone:** ______________**Fax:**_______________

Physician's Name: __________________________ **Date:**___________________

Parent/Guardian's Authorization By signing below: I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Hinsdale Township High School District 86 and it employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer) the lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse, and specifically consent to such practices. I further acknowledge and agree that, when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees, and agents, either jointly or severally, from any and all claims, damages, and causes of action or injuries, except a claim based on willful and wanton conduct, incurred or resulting from the administration or self-administration of medication.

Parent/Guardian's Signature:___________________________ **Date:** _____________