HINSDALE

hinsdale **central** high school

Hinsdale Central
High School
a partnership in
lifelong learning

Contact Information
55th & Grant Streets
Hinsdale, Illinois 60521

p 630.570.8000
f 630.887.1362
www.hinsdale86.org

Dear Parent or Guardian,

Your student's health record indicates an allergy to food, bee stings, and/or other substances. **If your child has a *history of anaphylaxis (a life-threatening allergic reaction)*, and your physician recommends the administration of an Epi-pen and/or Benadryl, please complete the enclosed Allergy Emergency Action Plan, Medication Authorization Form, and Individual Health Care Plan (IHCP).** This additional information will allow Health Services to effectively respond to your child's allergic condition.

Review the plan carefully with your student's physician and provide the requested signatures. **Also, please make sure the brand name, dose, route and instructions are documented on both the Medication Authorization Form and the Allergy Emergency Action Plan for any medications to be administered.** If Epinephrine is needed, your student should self-carry the medication with their physician's approval. Please also provide Health Services with a spare dose of all emergency medications prescribed for your child.

Please return the forms by July 1st of the upcoming school year to ensure that a plan is in place for the beginning of school. Please contact us with any questions.

Sincerely,

Central Health Office
p) 630-570-8595 f) 630-570-8599

ILLINOIS FOOD AND OTHER ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Student Name: _____ Date of Birth: _____
Phone Number: _____ ID#: _____
Health Care Provider: _____ Weight: _____

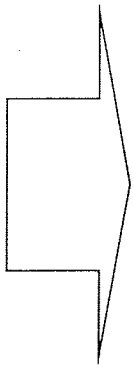
History of Asthma: ☐ **No** ☐ **Yes (Higher risk for severe reaction)**

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



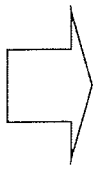
INJECT EPINEPHRINE IMMEDIATELY IN LATERAL THIGH

- 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.to
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.

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)

Parent/Guardian Signature: _____ Date:_____

Name of Staff Member(s) Trained	Title	Location/Room #	Trained by

LOCATION OF MEDICATION:

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

Rev 8/22/12 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

Individual Health Care Plan (IHCP) for _____

Allergens: _____

Problem: Anaphylaxis/Risk for Life-Threatening Allergy

Goal: Prevent allergic reaction from occurring and increase student's safety at school

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Anaphylaxis is a rare, life-threatening allergy to certain substances such as foods, bee stings, chemicals and medications. It occurs rapidly and can close off the breathing passages. If instant treatment does not occur, it can be fatal. It is important to note that there is little downside to giving epinephrine if it is not needed; however, delaying treatment can result in tragedy.

Responsibilities of Teachers, Coaches, Club Sponsors:

- Confidentiality Reminder: Please do not openly discuss the student's condition in the classroom.
- If the student complains of **any** allergy symptoms, immediately send him/her to Health Services with an escort or call Health Services at extension 8595/8596/8597 and we will come to you!
- Do not use food or products containing student's allergens in class experiments or projects.
- Teachers, Coaches, Club Sponsors, and Field Trip Sponsors who are District 86 employees are expected to review the Emergency Action Plan, which is located on the I Drive in the Health Plans at a Glance Folder, and understand how to assist the student.
- Teachers, Coaches, Club Sponsors, and Field Trip Sponsors can view the appropriate Epinephrine Injection Videos at www.epipen.ca/en/about-epipen/how-to-use-epipen and www.auvi-q.com/auvi-q-demo . It is important that you are able to properly administer an epinephrine injection in an allergic emergency. One-on-one demonstrations with a training device are available to you in the health office.
- Teachers, Coaches, and Club Sponsors will place a confidential copy of this plan in their personal file and another copy in their substitute information file along with seating charts, emergency lesson plans, etc.
- Substitute teachers will be familiar with the Emergency Action Plan and Epinephrine Injection Videos.

Responsibilities of Parents and Students:

- Students are responsible for their care in after school activities and clubs.
- 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 care 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, Auvi-Q, antihistamine, inhaler, etc.) to all extracurricular activities such as athletic practices and games, field trips and club events.
- Students are responsible to inform their coach, field trip sponsor or club sponsor of the medication's exact location i.e. sport bag on the field, backpack, fanny pack, etc. and ensure that it is in a location that is easily accessible.
- The student will not eat any homemade items brought to school by others. The student will read all food labels carefully and avoid eating any questionable food products.
- The student should carry surface wipes to clean individual desk and tabletops as needed.

_____ _____

Parent Signature Date

_____ _____

Building Nurse Signature Date

Hinsdale Central High School

MEDICATION AUTHORIZATION FORM

PHONE 630-570-8595 FAX 630-570-8599

Student Name: _____ Class/ID: _____ / _____

TO BE COMPLETED BY THE PHYSICIAN: (please print)

All medication (prescription or nonprescription, including generic Tylenol and ibuprofen) requires authorization **each school year**. It is the parent's responsibility to update student health information in the event of any change.

Please note**: Only **generic** Tylenol, Advil, or Motrin will be dispensed in the Health Office. If non generic is ordered, parent must supply the medication. **If medication below is not advised, delete or amend as needed.

Medication *Required* during School	**Dosage/Route**	**Time and Frequency**
Generic Tylenol	325-650 mg po	every 4-6 hours as needed
Ibuprofen	200-400 mg po	every 4-6 hours as needed

Other Medication *Required* during School	**Dosage**	**Time and Frequency**
EpiPen 0.3 mg IM for allergic reaction		
Benadryl 50 mg PO for allergic reaction		

Diagnosis requiring medication(s): _____

Intended effect/Possible side effects: _____

Other medication student is taking: _____

Medication student may carry and self-administer: Inhaler, insulin or Epi-Pen (circle if applicable). Please contact the school nurse at 630-570-8595 for details.

Self-Administered Medication: such as medication for asthma, diabetes, or severe allergy: 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 _____ **Date** _____

Physician's Name _____ **Phone** _____ **Fax** _____

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 _____

Address _____ Phone _____