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: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

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

Parent/Guardian Signature:_____ Date: _____

INDIVIDUAL HEALTH CARE PLAN (IHCP)
TO BE COMPLETED & SIGNED BY PARENT

- All guidelines indicated in Lincolnshire Prairie View District 103 Procedures for Supporting Children with Life Threatening Allergies will be considered and followed.
- Student should remain quiet with a staff member at the location where the symptoms began until EMS arrives.
- Notify the administrator and parent/guardian.
- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save the food eaten before the reaction, if possible and place in a plastic zipper bag to freeze for analysis.
- Provide a copy of the Emergency Action Plan to EMS upon arrival.
- Staff members on an off campus field trip will be trained regarding Auto injector use.

Individual Considerations

Location(s) of auto injector/rescue medications is/are kept:

☐ **NURSE** ☐ TEACHER ☐ STUDENT ☐ OTHER: _____

Transportation

- This student carries auto injector on the bus ☐ Yes ☐ No
- Auto injector can be found in ☐ Backpack ☐ Waist pack ☐ On Person ☐ Other (specify): _____
- Student will sit at front of the bus ☐ Yes ☐ No
- Other (specify) _____

Field Trip Procedure

- Rescue medication will accompany student during any off campus activities.
- The student should remain with the teacher or parent/guardian during the entire field trip ☐ Yes ☐ No
- Other (specify) _____

CLASSROOM (for students with food allergies)

- Parent/guardian should be advised of any planned activities involving food in advance.

This student is allowed to eat only the following foods:

☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the nurse/parent or _____

☐ Those approved by parent.

☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.

☐ Other (specify) _____

CAFETERIA (for students with food allergies)

☐ Student will sit at a specified allergen safe table.

☐ Student will sit at the classroom lunch table at a specified location.

☐ **NO Restrictions**

☐ Other _____

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.

I do hereby and forever agree to release, hold harmless, defend and indemnify the school district, its employees and agents from any and all claims, demands, damages, writ of action or causes of action, except for willful and wanton conduct, arising out of administration of said medication. I hereby acknowledge that the district and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self administration of medications, including epinephrine auto-injectors and asthma rescue inhalers.

_____

Parent/Guardian Signature Date

_____

School Nurse Signature Date

A copy of this procedure will be kept in the substitute folder and given to all staff members who are involved with the student.

References: Board Policy 7:250 and 7:270

LEADERS IN LEARNING

Lincolnshire-Prairie View School District 103
Administration Offices
1370 Riverwoods Road • Lincolnshire, Il 60069
847/295-4030 • FAX 847/295-9196
http://www.d103.org

Sprague School
FAX # (847) 945-6718

Half Day Shool
FAX # (847) 634-1968

Daniel Wright Junior High School
FAX # (847) 295-1560

Allergy History Form

Dear Parent/Guardian of: Date:

According to your child's health records, he/she has an allergy to:

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office/nurse.

1) When and how did you first become aware of the allergy?

2) When was the last time your child had a reaction?

3) Please describe the signs and symptoms of the reaction.

4) What medical treatment was provided and by whom?

5) If medication is required while your child is at school, the enclosed Emergency Action Plan (EAP) form can be used for this purpose and must be completed by a licensed medical provider and parent/guardian.

6) Please complete the enclosed EAP to describe the steps you would like us to take if your child is exposed to this allergen while at school.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

(Return completed form to School Nurse.)

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