

# 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): \_\_\_\_\_

ANTI-HISTAMINE (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: \_\_\_\_\_

**Appendix #2: CONFIDENTIAL**

**Individual Health Care Plan (IHCP) for** \_\_\_\_\_ **Allergens** \_\_\_\_\_

**PROBLEM:** Risk for anaphylaxis      **GOAL:** Prevent allergic reactions from occurring and ensure student's safety at school

**Parent (please answer the questions below): Check all that apply.**

- 1. I would like my child's emergency medication\* kept in:  
 The nurse's office\*\*     The classroom\*\*     Nurses' office and classroom\*\*  
 On the bus\*\*
- \*\*The number of boxes checked is the number of EpiPens® that must be provided by the parent.
- 2. If the emergency medication is kept in the classroom, the medication should be transported by school personnel wherever my child travels to within the school:  
 Yes     No
- 3. Does your child require an allergen free eating area?  
 Yes     No
- 4. I would like to accompany my child on field trips when appropriate.  
 Yes     No
- 5. I will encourage my child to wash his/her hands with soap and water or use a cleansing wipe before eating.  
 Yes     No
- 6. I will provide a shelf-stable allergen free snack that will be available in the classroom if needed.  
 Yes     No

Please list other accommodations needed at school:  
\_\_\_\_\_

\*Proper paperwork must be provided. \*\*The number of boxes checked is the number of EpiPens® that must be provided by the parent.

**Teacher Responsibilities**

- Ensure a student with a suspected allergic reaction is accompanied by an adult at all times.
- Keep a copy of the student's Emergency Action Plan and IHCP in the classroom sub folder.
- Inform parents of the allergic student within a week of any school-wide events where food will be served.
- Ensure that food or products containing the student's allergens are not used for class projects, science experiments, or celebrations.
- If the parent of a student with a food allergy is not attending a field trip, the student will be assigned to a staff member who has been trained to implement the Emergency Action Plan and is carrying the emergency medication.
- Plan for the following on field trips: oversee cleaning the table of the student with food allergies before eating, ensure the student with the food allergy washes his/her hands before eating, ensure the student with the food allergy eats only allergen free food or food supplied by the parent, carry a cell phone to call 911 if needed, and review the Emergency Action Plan before the field trip.
- Implement accommodations that parent indicated, "yes" in parent section.

**Appendix #2 Con't CONFIDENTIAL**

**Individual Health Care Plan (IHCP) for** \_\_\_\_\_ **Allergens** \_\_\_\_\_

<p><b>Principal Responsibilities</b></p> <ul style="list-style-type: none"><li>→ Ensure there are walkie-talkies available to playground and P. E. staff.</li><li>→ Delegate proper cleaning of the allergen free area in the lunchroom and classroom (when the classroom is used as a lunchroom).</li><li>→ Prohibit sharing or trading food at school.</li><li>→ Encourage students to bring healthy snacks to school and avoid bringing snacks made with peanuts or nuts.</li><li>→ Ensure student has an allergen free area available in the lunchroom if parent indicated an allergen free area is needed (see parent section).</li></ul>	<p><b>School Nurse Responsibilities</b></p> <ul style="list-style-type: none"><li>→ Educate all staff that interacts with the student about food allergy symptoms and the steps required to implement the Emergency Action Plan. Review emergency procedures with classroom teacher prior to field trips as needed.</li><li>→ Ensure access to emergency medication when developing plans for fire drills, lockdowns, etc.</li><li>→ If student rides the bus, provide a copy of the Emergency Action Plan to the bus driver.</li><li>→ A copy of the student's Emergency Action Plan and IHCP will be distributed on a need to know basis.</li></ul>
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The Individual Health Care Plan has been reviewed by the Parent/Guardian and School Nurse on \_\_\_\_\_  
Date

*The Emergency Action Plan and Individual Health Care Plan will be distributed to staff on a need to know basis.*

*A copy of the Emergency Action Plan will be given to the bus driver if the student uses bus transportation.*

### Appendix #3

#### **Annual Severe Allergy Survey – Parent Information**      **School Year** \_\_\_\_\_

Please provide us with information about your child's allergies. Annually, please update this form with new information. If there are questions, your school nurse will follow up with you.

Student Name \_\_\_\_\_

Grade \_\_\_\_\_                      Teacher \_\_\_\_\_

1. Please indicate what your child is allergic to by checking the appropriate box.

peanuts       bee sting       tree nuts       latex  
 milk       other \_\_\_\_\_

2. At what age did your child experience their first allergic reaction? \_\_\_\_\_

3. Please describe the type of allergic reaction he/she has had in the past?

itching, tingling, or swelling of lips, tongue, mouth  
 hives, itchy rash, swelling of the face or extremities  
 nausea, abdominal cramps, vomiting, diarrhea  
 tightening of throat, hoarseness, hacking cough  
 shortness of breath, repetitive coughing, wheezing  
 fainting, pale, blueness  
 other \_\_\_\_\_

4. Has your child seen a doctor for this allergy?      Yes  No

5. Has your child been seen at an emergency room because of an allergic reaction, and if so, what medication was given?

\_\_\_\_\_

6. When was the last time your child had an allergic reaction? \_\_\_\_\_

\_\_\_\_\_

7. How do you treat allergic reactions at home? \_\_\_\_\_

\_\_\_\_\_

8. Does your child have an epinephrine auto injector at home?       Yes       No

9. If yes, does your child know how to use the epinephrine auto injector?       Yes       No

10. Please indicate when your child reacts to the allergen by checking the appropriate box.

eats it       inhales it  
 touches it       other \_\_\_\_\_

11. May we share your child's allergy information with his/her classmates?       Yes       No

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please Return to **Nurse** as soon as possible.

**Appendix #4**

**Little Learner Program – 4<sup>th</sup> Grade / Self-Contained Classroom Letter to Parents**

Date:

Dear Parent/Guardian:

This letter is to inform you that a student(s) in your child’s classroom has severe food allergies to: \_\_\_\_\_ . Exposure to these allergens could cause a life-threatening reaction. It is our goal to ensure that every student in our school is safe. Our District has adopted a policy for managing students with food allergies. Our policy is in compliance with Public Act 96-0349 and meets the guidelines created by the Illinois State Board of Education and the Illinois Department of Public Health.

Because these students cannot be in contact with foods containing this/these allergen(s), **we are requesting that you not send these foods to school for snacks or treats.** Even trace amounts of these allergens could result in a severe allergic reaction. Sometimes these elements may be hidden in processed foods.

Please discuss the following with your child:

Do not offer, share, or exchange any foods with other students at school. Hand washing with soap and water, after eating, is necessary to decrease the chance of cross-contamination on surfaces at school.

If your child rides the bus, remind them that there is a “no eating on the bus” policy.

Thank you for your consideration and help in this matter. Please call if you have any questions or concerns.

Sincerely,

Child’s Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Homer Community Consolidated School District 33C**

**Appendix # 5**

**Extra Curricular Permission Form  
for Students with Severe Allergies**

Student Name \_\_\_\_\_

Emergency Parent Phone \_\_\_\_\_

You have indicated that your child has a severe allergy. Please indicate your preference for treatment during this activity. **You must return this signed form to the activity sponsor before your child can participate in any school sponsored extra-curricular activity.** Please check one and sign below.

\_\_\_\_\_ My child has a severe allergy to \_\_\_\_\_.

\_\_\_\_\_ My child does not require medication after school or during this extra-curricular activity for the treatment of his/her severe allergy.

\_\_\_\_\_ My child requires the use of an Epinephrine Auto Injector and/or an antihistamine for the treatment of severe allergy during the extra-curricular activity. He/she will carry and administer his/her own medication. I have completed the proper forms for Epinephrine Auto Injector carry and/or self-administration and submitted them to the health office. **Please note: If your child does not have his/her medication with him/her, he/she will not be allowed to participate.**

\_\_\_\_\_ My child requires the use of an Epinephrine Auto Injector and/or an antihistamine for the treatment of severe allergy during the extra-curricular activity. I give my permission for the event sponsor/coach to obtain the Epinephrine Auto Injector and/or an antihistamine stored in the Health Office prior to the activity. **I also recognize that I am responsible for returning the medications to the Health Office the following day for use during school hours.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Appendix #6

**Lunchroom Table Preference Form**

Date: \_\_\_\_\_

Dear Parents of: \_\_\_\_\_

For students who have a life-threatening allergy, we will provide an allergen-free table at lunch. Please sign and return this notice to the Health Office indicating where you would like your child to be seated. If you wish to change your preference, we ask that you send us written notification.

\_\_\_\_\_ allergen-free table

\_\_\_\_\_ regular lunchroom table

Please note that your child will sit at the allergen-free table until this form is returned.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date