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: (____)_____

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:**_____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name: Lindsey Queen RN, BSN Room: School Nurse Office

Name: PCHS Staff Room: _____

Name: _____ Room: _____

LOCATION OF MEDICATION

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)
414.272.6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital
800.543.7362 (800.KIDS DOC®)
http://www.childrensmemorial.org

Food Allergy Initiative (FAI)
212.207.1974
http://www.faiusa.org

Food Allergy and Anaphylaxis Network (FAAN)
800.929.4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.

Self-Administration of Medication
Policy Statement
Pinckneyville Community High School

Dear Parent or Guardian,

The Pinckneyville Community High School has received your request for self-administration of_____, for your child _____.

State law requires that we inform the parents or guardians of the student, in writing, that the school 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 medication by the student.

Before we can allow your child, _____, to self-administer the medication we must ask you to sign and return a copy of this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student with asthma, potential for a severe allergic reaction or diabetes may possess and use his / her medication while in school, at school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his / her medication.

I _____, acknowledge that Pinckneyville Community High School, District #101 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 medication by the above named student. I indemnify and hold harmless the school district and its employees and agents any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signed_____ Date_____
Parent or Guardian

School Nurse Signature _____ Date _____

Parent/Student Agreement to Carry Medications
Pinckneyville Community High School #101

I give permission for my child, _____, to carry the medications described below. * I understand that he / she must follow the rules listed below. I will notify the school of changes in medication if my child's condition changes.

*** Inhalers, epinephrine-pens, insulin and glucose tablets, are the only medication that may be carried by a student.**

Name of Medication	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____

Parent / Guardian Signature _____

Date _____

I, _____ a student at Pinckneyville Community High School District #101, agree to the following:

1. I have demonstrated the correct use of inhaler, epinephrine injector or insulin to the health care provider and school health personnel.

2. I agree to never share the medication with another person.

3. I agree to notify the nurse, teacher or other responsible adult who will seek further medical intervention as outlined in my Individual Health Action Plan when:

-there is not marked improvement after using inhaler (2 puffs)

-an allergic reaction is suspected

-epinephrine is used

-abnormal blood sugar is suspected

Student Signature _____Date _____

School Medication Authorization Form
Physician Authorization
Pinckneyville Community High School District #101

Student's Name _____ Birth Date _____ School/District _____ Date _____

Please complete the designated areas marked below and return to the school nurse. This information is confidential between the physician, parent, teacher, and school nurse. Thank you for your cooperation.

_____**Physician Authorization for Medication at School:**
I am requesting that the above named student take the following medication during school hours.

Name of Medication/Health Care treatment _____ Dosage/Route _____

Frequency/Time to be administered _____

Diagnosis requiring Medication _____

Side effects/Reactions to these medications to which the nurse and/or teacher should be alert. _____

_____**Asthma Plan:** Personal Best Peak Flow number:_____
If this student does have problem with "endurance" sports, please permit him/her to take the following medication:_____ *before* participating to *prevent* symptoms.

In case of breathing difficulty, acute asthma attack, have the child take prescribed medication: _____

Other instructions:_____

* If the treatment is ineffective or symptoms are severe, transport to the ER immediately.

_____**Authorization for Self-administered medication (asthma inhalers, Epi-pen, glucose)**
___ I have instructed _____in the proper way to use his/her medications. It is my professional opinion that he /she should be allowed to carry and use that medication by him/ herself.

___ It is my professional opinion that _____should not carry self-administered medication by him/herself.

_____**List other medications the child is receiving** _____

_____

_____ _____
Start Date/Stop Date Re-evaluation Date

_____ _____
Physician Signature Date signed

_____ _____
Physician's Emergency phone number Physician's address

5/2017