NIPPERSINK DISTRICT 2

Nippersink Middle School
10006 Main Street
Richmond, IL 60071
815-678-6811 Fax: 815-678-7210

Richmond Grade School
5815 Broadway
Richmond, IL 60071
815-678-6774 Fax: 815-678-2192

Spring Grove Elementary
2018 Main Street
Spring Grove, IL 60081
815-678-6724 Fax: 815-675-0030

Allergy Action Plan

Student's Name: ____

Date of Birth:________________________________ Teacher/Grade:___________________________________

ALLERGY TO:____

Asthmatic: ☐Yes* ☐No *Higher risk for severe reaction

TREATMENT

Symptoms: Give Checked Medication**

Symptoms		Give Checked Medication**	
If a food allergen has been ingested (or insect sting), but NO symptoms are present:		☐EpiPen	☐Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐EpiPen	☐Antihistamine
Skin	Hives, swelling on face or extremities, itchy rash	☐EpiPen	☐Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐EpiPen	☐Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐EpiPen	☐Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	☐EpiPen	☐Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale	☐EpiPen	☐Antihistamine
Other*	Allow student to self carry medication__________________	☐EpiPen	☐Antihistamine

*If a student self carries an EpiPen, parent agrees to keep an additional EpiPen in the Nurse's office

MEDICATIONS:

Medication	Dose	Form	Route
Epinephrine	☐EpiPen ☐EpiPen Jr. ☐Auvi-Q	Auto Injector	Inject intramuscularly in the outer thigh
Antihistamine: ☐Diphenhydramine HCL	☐12.5 mg ☐25 mg ☐50 mg ☐Other dose___________	Liquid Fast-melt Tablet Thin Strips	PO
Other Medication:			

EMERGENCY CALLS: If an EpiPen is utilized at school "911"/EMS will be activated

1. If EpiPen is given, *call 911*, state a severe allergic reaction and request additional epinephrine. ** Give new EpiPen every 15 minutes until ambulance arrives.
2. Call Parent/Guardian or emergency contact and healthcare provider.

Name_______________________________________ Ph#_________________________________ Ph#____________________________

Name_______________________________________ Ph#_________________________________ Ph#____________________________

Name_______________________________________ Ph#_________________________________ Ph#____________________________

These orders will be in effect for the current school year

____ ____

Parent/Guardian Signature Date Physician Signature (required) Date
Phone #:

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If you indicated that your child has a food or insect allergy, please fill out and return the attached form to the School Nurse prior to the first day of school.

Student Name: ________________________________ DOB: ________________________

Does your child have asthma? YES NO

1. What is your child allergic to?

2. Has your child had allergy testing done? (RAST, food challenge, scratch or other)- if so, what were the results? Please list the name and phone number of physician who performed the testing.

3. When was the last time your child had a reaction?

4. Please describe the reaction.

5. Was it resolved at the Doctor's office or did it require hospitalization?

6. Was your child prescribed Epinephrine (EpiPen)? If yes, when was the last time it was used?

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_______________________ School Year

Dear Parent or Guardian:

RE: ____
Student Name

____
Date of Birth

You have indicated that your child has an allergy to peanuts or nuts. Our goal is to provide a safe setting for your child during the school day. Our school provides a "nut free" table should you choose this for your child. Please indicate your wishes below and return this form to the School Nurse.

_______ YES, my child should be seated at the "nut free" table for lunch

_______ NO, my child does NOT need to be seated at the "nut free" table for lunch

____ ______________________

Parent Signature Date

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MEDICATION AUTHORIZATION

Prescription and Non-Prescription medications require both a prescriber and parent signature in order to be given during school. This form is to be renewed annually.

STUDENT NAME:___________________________________ Grade: ___________

DATE OF BIRTH:___________________________________

(*PART A-to be completed by the Prescriber*)

MEDICATION: ____

DOSAGE: ____

TIME OF ADMINISTRATION: ____

Reason for Medication: ____

Special Instructions: ____

Allergies: ____

PRESCRIBER SIGNATURE:________________________________ PRESCRIBER NAME:______________________

PRESCRIBER ADDRESS:____

PHONE NUMBER: ___________________________________ FAX NUMBER: _________________________

DATE: _______________

(PART B-to be completed by the parent/guardian)

All medication taken at school must be brought to school in the original container and be appropriately labeled by the pharmacy or manufacturer. Prescription medications must indicate the student name, the medication name and dose, the time the medication is to be administered and the provider's name. **ALL medication taken at school must be brought to the nurse's office (with exception of *self-carried* asthma medication or epinephrine auto-injectors).**

I hereby request and grant permission for District #2 School Personnel to dispense medication to my daughter/son, ___________________________________ according to the instructions above. I further waive any claims against the School District, its employees and agents arising out of the administration of said medication, and agree to hold harmless and indemnify the School District, its employees and agents; either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the administration of medication. If applicable, I give permission for my child to administer their own asthma or emergency allergy medications.

PARENT/GUARDIAN SIGNATURE:___________________________________ DATE:__________

PARENT NAME: ____