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:_____

Individual Food Allergy Health Care Plan

General Plan:

- ☐ Epinephrine will be stored in the: Nurses Office Class Room On Person
- ☐ If applicable, the *Self-Carry/Self-Administer Waiver* form has been signed & submitted.
- ☐ Student's symptoms of an allergic reaction include: _____
- ☐ Student can recognize an allergic reaction and knows when and how to seek help.
- ☐ Plan will be given to classroom teachers.

Bus Transportation Plan:

- ☐ All busses have a no food policy; drivers do not carry epinephrine; drivers are alerted to student's allergy.
- ☐ Student requires special considerations on bus: _____

Classroom Plan (Pre K & Elementary Grades):

- ☐ Student may eat only those foods approved and/or provided by parent.
- ☐ Parent/guardian must be advised of parties, events or projects involving food as early as possible.
- ☐ Classroom parents and students will be notified to avoid bringing allergens into the classroom.

Cafeteria Plan (Elementary Grades):

- ☐ Student will sit with classmates at an allergen-friendly table.
- ☐ Student will sit in a designated, visible and accessible seat at a general classroom table.
- ☐ No special seating is required.

Field Trip Plan:

- ☐ Special needs will be identified prior to any off-campus trip if food will be eaten or served.
- ☐ Parent/guardian must be notified in advance and allowed to accompany if possible.
- ☐ Prescribed medication & Emergency Action Plan must be reviewed and carried by certified staff member.

Other Needs: _____

Parent/Guardian Plan:

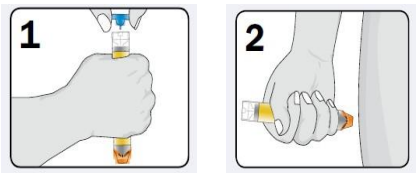
- ☐ I give Health Services staff permission to communicate with the Health Care Provider about this medication.
- ☐ I assume responsibility for supplying medication that will not expire during the course of its intended use.
- ☐ I will provide medication in the original prescription container with instructions by our health care provider.
- ☐ If my child is authorized to self-carry, additional medication will be kept in the health office as recommended.

Parent/Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____Date:_____

EpiPen (Epinephrine) Auto-injector Directions

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



Auvi-Q (Epinephrine) Injection Directions

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.