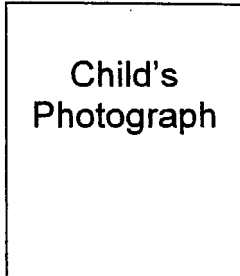


ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION



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: _____

Room: _____

Name: _____

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)**

1-800-414-2722-6071

<http://www.aaaai.org>http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdfhttp://www.aaaai.org/members/allied_health/tool_kit/ppt/**Children's Memorial Hospital**

773-KIDS-DOC

<http://www.childrensmemorial.org>**Food Allergy Initiative (FAI)**

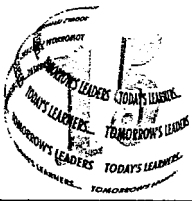
1-800-212-207-1974

<http://www.faiusa.org>**Food Allergy and Anaphylaxis Network (FAAN)**

1-800-929-4040

<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.



McHenry Elementary School District 15

1011 N. Green Street, McHenry, Illinois 60050

www.d15.org

Bonnie McCormack, RN, MA, IL/CSN
Director of Health Services
bmccormack@d15.org

Telephone: (815) 759-8502
Fax: (815) 759-8500
Information: (815) 344-7140

Dear Parent/Guardian of: _____ Date: _____

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

Please provide us with additional information about your child's health needs by responding to the following questions and return the completed form to your student's Health Office:

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

When was the last time your child had a reaction? _____

Please describe the signs and symptoms of the reaction? _____

What medical treatment was provided and by whom? _____

If medication is required while your child is at school, the enclosed Emergency Action Plan form must be completed by a licensed medical provider and parent/guardian.

Please describe the steps you would like us to take if your child is exposed to this allergen while at school: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____