ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Student's Photograph

Name: _____ **DOB:** ____/_____/___

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, cramping pain

INJECT EPHINEPHRINE 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
Injectable Epinephrine (Brand and Dose): _____
Antihistamine (Brand and Dose): _____
Other: (e.g., inhaler, bronchodilator if asthma) _____

MONITORING: Stay with child. Tell rescue squad epinephrine was given. Second dose of epinephrine can be given a few minutes after the first, if symptoms persist or recur. For a severe reaction, keep child lying on back with legs raised. Treat child even if parents cannot be reached.

___ Student may carry epinephrine ___ Student may self-administer epinephrine

Call 911

EMERGENCY CONTACTS:

Parent/Guardian: _____ Phone: (_____) _____
Name/Relationship:_____ Phone: (_____) _____

Physician Signature: _____ **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 Government 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:** _____

This Care Plan has been completed and reviewed by physician, student, parent, and School Health Assistant. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.