

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): _____

ANTI-HISTAMINE (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: _____ (Required) Phone: _____ Date: _____

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
- Student's symptoms of an allergic reaction include _____
- Student can recognize an allergic reaction and knows when and how to seek help.

Classroom Plan:

- 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.

Field Trip Plan:

- Prescribed medication & Emergency Action Plan must be reviewed and carried by a 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:** _____

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.
- 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 reaction.

LOCATION OF MEDICATION

- Student to carry
- Health Office/Designated Area for Medication
- Other: _____



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.