ALLERGY: Individual Health Care Plan

Diagnosis: Risk for anaphylaxis GOAL: Prevent allergic reaction at school.

Individual Health Care Plan for____

Allergies:____

Grade/Teacher_____________________________

My child reacts to his/her allergen if he/she is near it, touches it, or consumes it?__________

____

In the past my child's reaction symptoms included___________________________________

____

Medications used to stop the reactions included_____________________________________

My child will have emergency medications at school. YES NO

SCHOOL RESPONSIBILITY: Medications will be stored in the health office and all staff who interact with students will be trained annually on anaphylactic emergencies.

PARENTS RESPONSIBILITY: Medications must accompany current signed orders from a physician. It is the parents responsibility to insure that the school's supply is maintained and medications are not expired.

My child requires a "Nut Free" classroom. YES NO

SCHOOL RESPONSIBILITY: Teachers will ensure that foods used for class projects or experiments will not contain the student's allergen.

My child requires an allergen free eating area YES NO

SCHOOL RESPONSIBILITY: Lunch tables are washed between students. Food sharing is discouraged.

My child understands how to avoid exposure to his/her allergen. YES NO

I would like to accompany my child on field trips?______________________________

SCHOOL RESPONSIBILITY: Students not accompanied by a parent will be assigned to a staff member who will carry the emergency medication and who is trained to implement the Emergency Action Plan.

Parent/Guardian Signature__________________________________Date________________

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: ____________

Allergy to: ______________________

Weight: ________ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

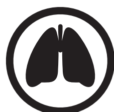
PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

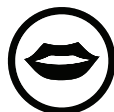
[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.**



LUNG
Short of breath, wheezing, repetitive cough

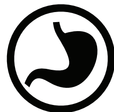
HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing



MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness



GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

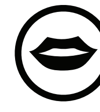
- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

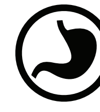
[ ] **If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

NOSE
Itchy/runny nose, sneezing



MOUTH
Itchy mouth

SKIN
A few hives, mild itch



GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if asthmatic): ____________

____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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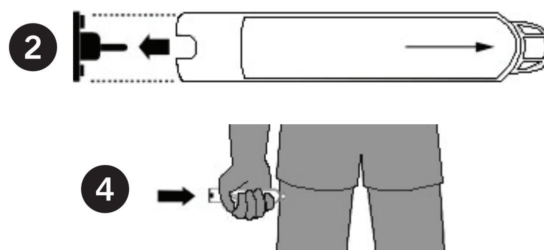
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

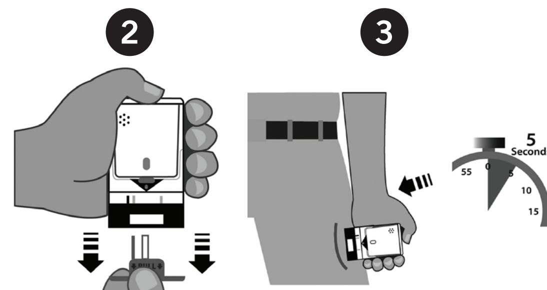
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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, USP) 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.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: __________

PARENT/GUARDIAN: ____________________ PHONE: __________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

NAME/RELATIONSHIP: ____________________

PHONE: ____________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

LaGrange Highlands School District 106
1750 W. Plainfield Road, LaGrange, IL 60525
Elementary School Health Office: (708) 485-3418
Elementary School Health Office Fax: (708) 485-3611
Middle School Health Office: (708) 485-3432
Middle School Health Office Fax: (708) 485-3593

School Year: _________________ Grade and Teacher: _____________________________

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

(To Be Completed Annually by Physician)

Student Name: _______________________________________ Date of Birth: _________________________

This child is under my medical care for ________________________ and medication is required during the school day.
(Diagnosis)

Name of Drug	Dosage	Route	Frequency	Time To Be Given At School	Side Effects

☐ This student has been instructed in the self-administration of the above epinephrine auto-injector (ONLY), knows the circumstances under which to use the medication, and may carry the auto-injector. _______________________
Prescriber's initials

Signature of Physician ___________________________________ Date _____________________ OFFICE STAMP

Printed Name of Physician _______________________________Physician's Office and Emergency Phone # ______________

Asthma Inhalers - Parents please attach prescription label to the back of this form if student is self-administering.

☐ My child has my permission to self-administer his/her asthma inhaler. ________________ Parent's initials
By initialling here, the parent/guardian is responsible for the student carrying and maintaining their own inhaler

(To Be Completed By Parent or Legal Guardian)

I give permission for my child to receive the above medication(s) as directed by the physician. I will bring the medication to the school nurse in a container labeled by the pharmacy. I will provide a written doctor's order if the medication dosage is changed or the medication is discontinued. For all medications other than self-administered asthma medications or epinephrine auto-injectors, I understand that it is the responsibility of the student to report to the District 106 Health Office at the scheduled time to receive the medication. I further completely release and excuse LaGrange Highlands District 106 and its employees and agents of any liability or obligation of any nature in any way related to the District's medication policy and procedure.

"Self-administration" means that the student has the discretion as to the use of his/her asthma medication or epinephrine auto-injector (ONLY). Therefore, as the parent/guardian, I acknowledge that the student is responsible for having asthma medication or an epinephrine auto-injector available as needed, and that the student has demonstrated competency in the proper way to use the medication.

I, the parent/guardian of the above student acknowledge that, District 106, along with its employees and agents, incur no liability as a result of any injury arising from the student's self-administration of asthma medication or epinephrine auto-injector. I indemnify and hold harmless the district, along with its agents and employees, against any claims (except a claim based upon willful and wanton conduct).

Parent signature and date: ____ Telephone: __________________________

Emergency contact name: ____ Telephone: __________________________