St. Theresa School Allergy Action Plan (2018-2019)

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Students with an allergy need to have a care plan on file at school to manage the student's condition and to assist school personnel to intervene appropriately should an episode occur.

- Physician's Prescription needs to be *updated yearly.*
- All Epi Pens and Benadryl (Diphenhydramine) will be kept in the Nurse's office and are available whenever the student is on the school campus.
- Additional Epi pens may be required for after school sports. This is determined on an individual basis.
- Homeroom teachers that have students in their classrooms that require carrying an Epi pen at all times, *per Doctor's order*, will store theirs in the classroom and a plan will be developed for transporting them throughout the day.
- To continue to keep our STS environment safe for all students, all staff members and lunch supervisors will be trained in the proper use of an Epi Pen. The recognition of symptoms associated with anaphylaxis will also be reviewed at the beginning of each school year.

When a food or bee allergy reaction is suspected, the following steps will be taken immediately:

1. CALL 212 (NURSE'S OFFICE)
2. STATE THE STUDENT'S NAME & LOCATION
3. NURSE WILL GO IMMEDIATELY TO THE LOCATION TAKING ALONG THE EPI PEN AND BENADRYL
4. STUDENT WILL BE ASSESSED BY THE NURSE FOR APPROPRIATE TREATMENT
5. IF FOR ANY REASON THE NURSE IS NOT AVAILABLE OR DELAYED AND A STUDENT'S SYMPTOMS ARE POTENTIALLY LIFE THREATENING – 911 WILL BE CALLED
6. 911 WILL BE CALLED IF THE EPI PEN WAS ADMINISTERED.

If there are any questions or concerns, please contact the Nurse's office at 847-359-1820 Extension 212

St. Theresa School Student Agreement to Carry Epi Pen For Self-Medication (2018-2019)

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1. Student has demonstrated the correct use of the Epi-Pen, including removal from container, self-injection into outer thigh, and requesting another individual to notify 911 immediately as well as school health personnel.
2. Student agrees NEVER to share the Epi Pen with another person.

Student Signature_____

Grade _____ Homeroom _____ Date _____

Parent/Guardian Acknowledgement

I give permission for my child _____ to carry an Epi Pen, as prescribed by his/her physician. I understand that he/she must follow the rules listed above. I will notify the school of any changes in the medication or my child's condition. I also have submitted the required forms needed to allow the administration of medication at school.

Parent/Guardian Signature _____ Date _____

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:_____

To be updated by parent/guardian/physician annually

Physician's Order

Student _____ Grade _____

_____ _____ _____

Medication/ Health Care Treatment Dosage Time(s) to be administered

_____ _____

Intended effect of this medication Expected side effects, if any

_____

Other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY:**
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

Physician's/ Prescriber's Name (PRINT) Emergency telephone number

_____

Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____,
(Please circle one)

20 ___, by _____ on behalf of
Signature of Principal

_____School, _____ , Illinois

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To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

_____ SCHOOL, _____, ILLINOIS

Student Name (Last, First, Middle)	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

Parent/Guardian (PRINT)	Parent/Guardian (PRINT)
Parent/Guardian (SIGNATURE)	Parent/Guardian (SIGNATURE)
Address	Address
City, State, Zip Code	City, State, Zip Code
Home Phone Business Phone	Home Phone Business Phone

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