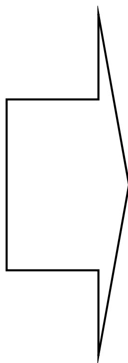
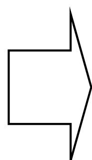
ILLINOIS FOOD AND OTHER ALLERGY
EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Student Name: ________________________________ Date of Birth: __________
Phone Number: _______________________________ ID#: ________________
Health Care Provider: ___________________________Weight: ______________

History of Asthma: ☐ **No** ☐ **Yes (Higher risk for severe reaction)**

ALLERGY: (check appropriate) **TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY**

☐ **Foods** (list):____
☐ **Medications** (list):____
☐ **Latex:** Circle one: Type I (anaphylaxis) Type IV (contact dermatitis)
☐ **Stinging Insects** (list type):__________________________________
☐ **Other** (list):____

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:		INJECT EPINEPHRINE IMMEDIATELY IN LATERAL THIGH
Lung++ Shortness of breath, wheeze, repetitive cough **Heart: ++** Pale, blue faint, weak plus, 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, cramps		– Call 911 – Begin monitoring (see emergency protocol below) – Additional medications – Antihistamine – Inhaler (bronchodilator) if asthma +++When in doubt, use epinephrine. Symptoms can rapidly become more severe.
MILD SYMPTOMS ONLY **Mouth:** Itchy mouth **Skin:** A few hives around mouth/fact, 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.

DOSAGE: TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY

- **EPINEPHRINE:** Inject into outer thigh ☐ **0.3 mg** OR ☐ **0.15 mg**
- **ANTIHISTAMINE:** Diphenhydramine (Benadryl®) ____ mg (Liquid or Fastmelts). ONLY if able to swallow.
- **OTHER:** e.g. inhaler-bronchodilator_________________________________

☐ This child has received instruction in the proper use of:
Circle One - Auto Injector - EpiPen® - Auvi-Q®. It is my professional opinion that this student **SHOULD** be allowed to carry and use the auto-injector independently. The child knows when to request antihistamine and has been advised to inform a responsible adult if the auto-injector is self-administered.
☐ It is my professional opinion that this student **SHOULD NOT** carry the auto-injector.

Health Care Provider Signature:______________________Phone:___________ Date: _________

EMERGENCY PROTOCOL

1. **Call 911. Stay with the child. State that an allergic reaction has been treated. Note the time of the injection. Circle the location of the injection site with a permanent marker.**
2. **A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur.to**
3. **Treat for shock. For a severe reaction, consider keeping child lying on back with legs raised prepare to do CPR.**
4. **Call parent/guardian to notify of reaction, treatment and student's health status.**

Side 2 – To be completed by Parent/Guardian

Student Name:_________________________________ **Date of Birth:**_______________

Parent/Guardian Authorizations:

- ☐ **I want my child to carry an auto-injector.**
- ☐ **I do NOT want my child to self-administer epinephrine**.

EMERGENCY CONTACTS:

	NAME	HOME PHONE	WORK PHONE	CELL PHONE
Parent/Guardian				
Parent/Guardian				
Other:				

I understand that submission of this form may require the Nurse to contact and receive additional information from your health care provider regarding the allergic condition(s) and the prescribed medication. My signature below provides authorization of this contact.

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. The school district or nonpublic school and its employees and agents, including a physician providing standing protocol or prescription for school epinephrine auto-injectors, are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse. 105 ILCS 22-30(c)

Parent/Guardian
Signature: ____Date:________________

Name of Staff Member(s) Trained	Title	Location/Room #	Trained by

LOCATION OF MEDICATION:

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