ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

See Attached for Child's Photograph

NAME:_____ **D.O.B:**____/____/____

STUDENT ID #:_____ **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:**_____