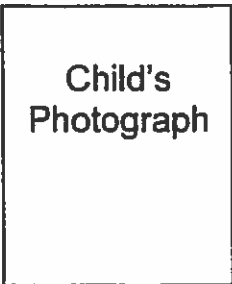


ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION



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: _____ (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: _____

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.
- If food was provided by school cafeteria, review food labels with head cook.
- 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 another reaction.

TRAINED STAFF MEMBERS

Name: _____

Room: _____

Name: _____

Room: _____

Name: _____

Room: _____

LOCATION OF MEDICATION

Student to carry

Health Office/Designated Area for Medication

Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)

414-272-6071

<http://www.aaaai.org>

http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf

http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital

773-KIDS-DOC

<http://www.childrensmemorial.org>

Food Allergy Initiative (FAI)

212-207-1974

<http://www.faiusa.org>

Food Allergy and Anaphylaxis Network (FAAN)

800-929-4040

<http://www.foodallergy.org>

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.

Insert Sponsor Name

Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact _____ at _____
Telephone (Include Area Code) *Name*

PHYSICIAN STATEMENT

- Does child have a disability according to 7 CFR Part 15d that requires food accommodation? (Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)
 No If no, go to item 2 below.
 Yes If yes, provide the following information and complete items 3, 4, and 5 below.
 - What is the disability? _____
 - What major life activity is affected? _____
 - How does the disability restrict the diet? _____
- Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.

★ 3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

★ 4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

5. _____
Date *Signature of Physician*

FOR OFFICE USE ONLY:	
<input type="checkbox"/> Form received on _____	
<input type="checkbox"/> Form incomplete. Parent contacted on _____	
<input type="checkbox"/> Form complete. Accommodation will not be made.	<input type="checkbox"/> Child does not have a disability <input type="checkbox"/> Request not reasonable
<input type="checkbox"/> Form complete. Accommodations will begin on _____	
_____	_____
<i>Date</i>	<i>Signature of Food Service Director/Contact</i>

