GENEVA COMMUNITY UNIT SCHOOL DISTRICT #304
DEPARTMENT OF NURSING

SEVERE ALLERGY MANAGEMENT PLAN

CHILD NAME: _____ Grade: _____
School Year: _____
Effective date of plan: _____

According to your child's health records, he/she has been diagnosed with a severe food or an environmental allergy. To allow us to better care for your child, please provide us with the following information and return it to your school nurse's office.

IT IS STRONGLY RECOMMENDED THAT PERSONS WITH POTENTIALLY LIFE THREATENING HEALTH CONDITIONS WEAR A MEDICAL IDENTIFICATION TAG.

DOES THIS CHILD HAVE AND WEAR A MEDICAL ALERT ID: YES NO

I. CHILD HISTORY

Substances or foods that cause allergic reaction:
_____

Please circle below:
Your child's allergic reaction is triggered by:
Ingestion *Inhalation* *Skin Exposure to the allergen*

Type of reaction (please circle all that apply):

Sudden onset	Sneezing
Wheezing	Coughing
Difficulty breathing	Difficulty swallowing
Hoarseness of voice	Itching, with or without hives
Tingling sensation around face/mouth	Sweating or anxiety
Nausea	Abdominal pain
Vomiting, diarrhea	Dizziness, fainting
Swelling of eyes, lips, face, tongue,	

Other symptoms:_____

Is this child also asthmatic? Yes NO

II. MEDICAL MANAGEMENT

HOME MAINTENANCE MEDICATIONS

Name of Medication	Dosage	Times Taken	Side Effects

III. SCHOOL MANAGEMENT

Are medications needed at school? YES NO

If yes, list medications: _____

****Complete the **Medication Authorization Form** with signature from parent and physician and return it to your child's school nurse's office.*

If your child requires an injection of **epinephrine,** is your child able to **self-administer**? YES NO

Will your **child self-carry epinephrine?** YES NO

- **If yes, it is highly recommended that a 2nd epinephrine injector still be kept in the school nurse's office.**
- **Please note that you will need an additional epinephrine auto injector for extracurricular activities as the school nurse's office is not open outside of regular school hours**.

Other concerns:

_____

_____

IV. EMERGENCY INFORMATION

An Allergy Action Plan is HIGHLY Recommended- Please discuss this with your physician. A template of this plan is provided for you. See attached.

Does your child have an Allergy Action Plan? YES NO

Will you provide the school with a copy of this plan? YES NO

Emergency Protocol

If your child has an allergic reaction or any difficulty at school, the nurse will institute the following emergency protocol:

- Medical management as prescribed
- ***911*** will be called in severe emergencies and/or when an Epinephrine autoinjector has been used
- Parent or emergency contact will be called
- The child's doctor will be called if parent or emergency contact cannot be reached.

EMERGENCY CONTACT INFORMATION:

Name Relationship to Child Phone Numbers

_____

_____

Physician Name_____ Phone Number_____

The allergy management plan may be shared with school staff to support your child's safety in school. Parents are encouraged to discuss their child's medical needs with the transportation department as well as sponsors/coaches working with your child before or after school hours.

Parent 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:_____

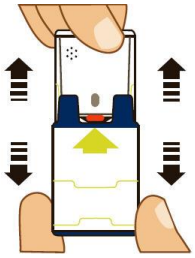
<u>Directions for Epinephrine Autoinjectors</u>: <u>If an Epinephrine Autoinjector is used ALWAYS call 911</u>

<u>EpiPen® and EpiPen® Jr. Directions</u>

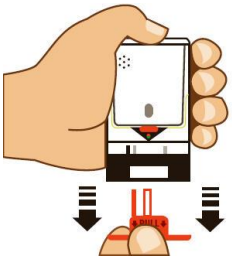
- **Pull off gray activation cap.**
- **Hold black tip near outer thigh (always apply to thigh).**
- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions.**
- **Hold in place and count to 10.**
- **Remove the EpiPen® unit and massage the injection area for 10 seconds.**
- **Give the EpiPen® unit to the emergency personnel; take care not to touch exposed needle**
- **If symptoms don't improve after 10 minutes, a second dose may be administered**

<u>Auvi-Q® Directions</u>

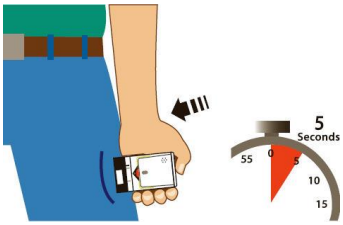
1. Pull Auvi-Q® from the outer case Do **not** proceed to step 2 until you are ready to use Auvi-Q®. If not ready to use, replace the outer case.



2. Pull off Red safety guard To avoid an accidental injection, **never** touch the black base of the auto-injector. If an accidental injection does occur, seek medical help immediately. NOTE: The safety guard is meant to be tight. ***Pull firmly to remove.***



3. Place black end against the middle of the outer thigh (through clothing, if necessary), then press firmly and hold in place for 5 seconds. Each device is a single-use injection. Only inject into the middle of the outer thigh (upper leg). Do not inject into any other location. **Note: Auvi-Q® makes a distinct sound (click and hiss) when activated. This is normal and indicates Auvi-Q® is working correctly. Do not pull Auvi-Q® away from your leg when you hear the click and hiss sound.**



4. Seek medical attention immediately
Replace the outer case and take your used Auvi-Q® with you to a healthcare professional for proper disposal and a prescription refill.