Central Community Unit School District 301
Dr. Todd Stirn, Superintendent
Student Services Department, Health Services Division

Date:_____

To the Parent / Guardian of _____,

To promote success and well-being of students at risk for **significant allergic reactions**, the nursing staff works closely with school personnel, students, their families, and the student's healthcare providers to establish an effective individual healthcare plan (IHP) for school. The following guidelines have been adopted by the district and must be submitted yearly to promote student safety. *Choose one:*

(A) If **no medication will be kept at school,** fill out the IHP form only and submit it to school.

(B) Medications may be **kept in the health office** when:
-there are orders from the healthcare provider on the Allergy/Anaphylaxis Action Plan (MedA) Form
-**and** an IHP has been completed by the parent/guardian or emancipated student and reviewed by the nurse
-**and** a copy of the prescription label is attached to the medication.

(C) An epinephrine auto-injector may be **carried by the student** (but not *self*-administered) when:
-there are orders from the healthcare provider on the Allergy/Anaphylaxis Action Plan (MedA) Form
-**and** an IHP has been completed by the parent/guardian or emancipated student and reviewed by the nurse
-**and** the parent/guardian or emancipated student consents on the Authorization to Self-Carry
-**and** a copy of the prescription label is attached to the medication.

(D) A student may **self-administer and self-carry** epinephrine when **at the start of each school year**:
-there are current orders from the healthcare provider on the Allergy/Anaphylaxis Action Plan (MedA) Form
-**and** an IHP has been completed by the parent/guardian or emancipated student and reviewed by the nurse
-**and** the parent/guardian or emancipated student consents on the Authorization to Self-Administer/Carry
-**and** a copy of the prescription label is attached to the medication
-**and** the student agrees to inform school staff immediately if epinephrine is self-administered.

A copy of each form is attached. Please have necessary documents completed and call the nurse at your child's school to schedule a meeting to review documents and implement the plan.

**Respectfully,**

**Central CUSD 301 Health Services Staff**



| | CHS | CMS | PKMS | HBT | CT | PV | LL |
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# Allergy / Anaphylaxis Action Plan & Treatment Authorization (Med A)

Place Student's Picture Here

**Name:** _____ **D.O.B.:** _____
**Allergy to:** _____
**Weight:** _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

**Extremely reactive to the following:** _____
**THEREFORE:**

☐ If checked, give epinephrine immediately for ANY symptoms.
☐ If checked, give epinephrine immediately, ***for any exposure/contact /ingestion*** *even if NO symptoms.*

**If SEVERE Symptoms after suspected or known Ingestion or contact:**

**One or more** of the following:
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 and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

**1. INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

**If MILD Symptoms only:**

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

**1. GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals & parent
3. If symptoms progress (see above), USE EPINEPHRINE

## Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

☐ If checked, give antihistamine for ANY symptoms.
☐ If checked, give antihistamine ***for any exposure / contact,*** *even if NO symptoms*

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Should student carry epinephrine auto-injector with him/her? Yes No

Has been instructed on & is he/she capable of self-administering epinephrine. Yes No

## Monitoring

***Stay with student; alert healthcare professionals and parent*** .
Tell rescue squad epinephrine was given & request epinephrine. Note the time epinephrine was given.
A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.
For a severe reaction, consider keeping student lying on back with legs raised.
Treat student even if parents cannot be reached.

| *Print* **Name of Healthcare Provider/Physician** | **Signature** | **Phone Number** | **Date** |
|---|---|---|---|
| | | | |

*Form adapted from FAAN (www.foodallergy.org) and ISBE Food Allergy Action Plan*

Fax to Central CUSD 301 Health Services:

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Central Community Unit School District 301
Student Services Department, Health Services Division

# Individual Healthcare Plan for Student with Allergies (IHP)

Photo Here

Name: _____ D.O.B. _____

School _____ _____ Grade ____ ____ Homeroom ____ ____

Allergy to: _____

Typical symptoms: _____

Does student have asthma? No Yes Inhaler @ school? No Yes _____

Plan is effective for one year from the date of the healthcare provider's order or the school nurse's review, unless otherwise specified

**Treatment Plan for School** (Please carefully review the treatments below and check all that apply)

- ☐ Avoid ingestion of _____
- ☐ Avoid contact with _____
- ☐ Student competent to independently manage condition; he/she will notify staff of any problems
- ☐ Notify parent if symptoms
- ☐ Notify parent if exposure
- ☐ Contact parent for medication _____
- ☐ Antihistamine: _____ in school health office
- ☐ Epinephrine: _____ in school health office
- ☐ Student carries epinephrine (exactly where:) _____; adult must administer (***CANNOT be in locker)***
- ☐ Student carries epinephrine, is competent to self administer, and Authorization to Self-Carry & Administer is signed
- ☐ Sit at Hot Lunch Table _____
- ☐ Other: _____
- ☐ Other: _____

**Additional Instructions/Accommodations or Coexisting Conditions** _____

_____

_____

**Contact Information**

| Name | Relationship | Cell Phone | Home Phone | Work Phone |
|---|---|---|---|---|
| #1 | | | | |
| #2 | | | | |
| #3 | | | | |
| #4 Healthcare Provider | | | | |

Authorization: . I hereby grant permission for the above named school to administer the medication routine described herein for the above named child. I further give the district nursing staff permission to be in contact with the healthcare provider with regard to the medication order and the response my child has to the medication. I hereby authorize CCUSD 301 health personnel to release my child's health information/records to teachers, administration, transportation, sports coaches, and food service personnel for the purpose of treating or preparing for a medical situation for my child. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that the records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights & Privacy Act.

Parent/Guardian Signature _____ Date _____

Student Signature if emancipated _____ Date _____

Signature of Nurse _____ Date _____

Fax to: Central CUSD 301 Health Services: Expiration Date _____

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Central Community Unit School District 301
Department of Student Services – Health Services Division

# Authorization for Self-Administration and/or Self-Carry

## of Asthma and/or Epinephrine Medication

Name of Student _____ Date of Birth: _____

School _____ Grade/ Homeroom _____ School Year _____

Diagnosis _____ Medication _____

I hereby acknowledge that I am the above referenced student or the parent/legal guardian of the above referenced student and that I am primarily responsible for administering medication to said child. However, in the event that I am unable to do so, I hereby authorize Central Community Unit School District 301 to allow *(circle one or both)* **self-carry / self-administration** of the lawfully prescribed *(circle one or both)*: **asthma / epinephrine** medication during the following: (1) while in school; (2) while at a school sponsored activity; (3) while under the supervision of school personnel; and/or (4) before or after normal school activities. I attest that the student has been instructed on and is capable of self-administering and that he/she understands the need for the medicine and to report any side effects to school staff. I further attest that the above referenced student has been instructed to report each time the medicine is used during any of the above times to staff in the building.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from self-administration of asthma / epinephrine medication. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties from and against any and all claims, damages, causes of action or injury incurred or resulting from self-administration of said medication.

Print Name of Parent / Guardian _____

Signature of Parent / Guardian _____ Date _____

Print Name of Emancipated Student _____ D.O.B. _____

Signature of Emancipated Student _____ Date _____


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| Fax | 847-464-6039 | 847-464-0233 | 847-717-8105 | 847-464-6022 | 847-717-8006 | 847-464-6024 | 630-387-7912 |

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