Dear Families,

Your child has been identified as having an allergy or asthma. Families are required to complete an Allergy Action Plan and/or an Asthma Action Plan depending on the needs of their child. We feel these forms detail the best procedures to follow in case your child has an allergic or asthmatic reaction while at school.

Please complete the attached forms and return it to the school office at your earliest convenience.

1. **Parent Questionnaire**
2. **Allergy Action Plan** (and/or) **Asthma Action Plan** (completed in conjunction with a physician)
3. **Medication Consent Form**

If your child has an **ALLERGY** we ask that you supply SLC with the following:

- Two small photos of your child (passport photos are ideal).
- Two up-to-date Epi-Pens (if your child has been prescribed one).
- Attach an allergen-notification to your child's lunch box (any kind of sticker will do).
- Other prescribed medication that might be given during an allergic reaction (like Benadryl, Epi-Pen, etc.)

If your child has **ASTHMA**, we ask that you supply SLC with the following:

- Two small photos of your child (passport photos are ideal).
- All necessary medication (Antihistamine, Inhaler, Benadryl, etc.)

If your child's allergy or asthma is not life threatening, and your child will not be taking any medication for the condition at school a parent/guardian must sign the Emergency Health Care Plan waiver.

Sincerely,

The SLC Governing Board
The SLC Administrative Team

School for Little Children
Educating. Nurturing. Inspiring.

Questionnaire for Parents/Guardians of a Child with Allergies

Childs Name:	**DOB:**

1. What is your child allergic to?_____

_____

2. What route of exposure to the allergen will cause your child to react?

□ *Absorption (through skin contact)*
□ *Inhalation (breathing in the allergen)*
□ *Injection (stings/bites etc)*
□ *Swallowing (oral ingestion)*

_____

3. What symptom does your child show when exposed to the allergen?

□ Breathing problem (shortness of breath, wheezing)	□ Vomiting
□ Runny eyes/nose	□ Diarrhea
□ Swelling	□ Rash
□ Itch	□ Welts
Other:	

4. What area of your child's body is usually affected?

□ Face □ Arms □ Hands □ Trunk □ Legs □ Feet

5. Is medication prescribed for the condition? □ Yes □ No

6. What is the name of the medication? _____

_____

7. Will the medication need to be given at the center? □ Yes □ No
(If yes, please complete the Physician and Parent Consents to Administer Medication)

8. Has Hospitalization been needed in the past for allergies? □ Yes □ No
If Yes, please explain (when, how often, etc.) _____

_____

9. Does your child know she/he has this allergy? □ Yes □ No

10. Does your child usually tell an adult when she/he is having a reaction? □ Yes □ No

11. Does your child require special accommodations when eating? □ Yes □ No

12. What do you usually do when your child has a reaction? _____

---

13. Does your child have asthma? □ Yes □ No

The Usual Treatment For A Severe Allergic Reaction Is To:

- Administer prescribed medication per written doctor's orders
- Call 911
- Notify Parents/guardians:

  Students Home phone #:

  Mother/guardian name:_____phone:_____

  Father/guardian name:_____phone:_____

What is your preferred hospital?_____

Name of Doctor:_____Doctor phone:_____

Parent Signature: _____ **Date:** _____

- *This information should be documented on the Child Enrollment Status form*
- *This information should be shared with the education & lunch and learn staff*

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:_____

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.

Print Reset Form

Medication Consent Form

To be completed by a Parent/Guardian

I, _____, parent/guardian of _____ request that the staff of School for Little Children administer the prescription or non-prescription medications listed below to my child. I agree and fully understand that SLC will not be responsible for any side effects, adverse reactions or medical emergencies that my child may experience as a result of taking the medication. I also understand that the person who will be administering the medication is not trained by a health care professional.

Child's Name:_____ **DOB:**_____

Emergency contact: _____ **phone**:_____

Child's known allergies:_____

Reason Child is taking the medication:_____

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

Name of Medication	
Expiration Date	
Dosage to be given	
Route of Administration (shot, liquid, etc.)	
Time/Frequency to be administered	

Physician Name:_____**Physician Phone:**_____

- I give the SLC staff permission to speak to the prescriber above and to exchange information related to my child.
- I authorize SLC staff to administer the medication as specified to_____

Parent Name_____

Parent Signature:_____

Date:_____