



# SAINT RITA OF CASCIA HIGH SCHOOL

AN AUGUSTINIAN COLLEGE PREP SCHOOL

*Veritas † Unitas † Caritas*

## Allergy History Form

(Return to Nurse/Designated School Personnel (DSP))

Dear Parent/Guardian of: \_\_\_\_\_ Date: \_\_\_\_\_

According to your child's health records, he has an allergy to: \_\_\_\_\_

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

1) When and how did you first become aware of the allergy?

2) When was the last time your child had a reaction?

3) Please describe the signs and symptoms of the reaction.

4) What medical treatment was provided and by whom?

5) If medication is or may be required while your child is at school, the enclosed Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian, along with the medication administration request form.

6) Please describe the steps you would like us to take if your child is exposed to this allergen while at school. ( e.g. follow emergency action plan)

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Procedures for Managing Life-Threatening Food Allergies in Illinois Schools ( sample ) Illinois State Board of Education and Illinois Department of Public Health

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# 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

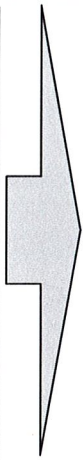
Weight: \_\_\_\_\_ lbs

**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: \_\_\_\_\_ (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/patients/resources/fact_sheets/food_allergy.pdf)

[http://www.aaaai.org/members/allied\\_health/tool\\_kit/ppt/](http://www.aaaai.org/members/allied_health/tool_kit/ppt/)

### Children's Memorial Hospital

800.543.7362 (800.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.