NIPPERSINK DISTRICT 2

Nippersink Middle School
10006 Main Street
Richmond, IL 60071
815-678-6811 Fax: 815-678-7210

Richmond Grade School
5815 Broadway
Richmond, IL 60071
815-678-6774 Fax: 815-678-2192

Spring Grove Elementary School
2018 Main Street
Spring Grove, IL 60081
815-678-6724 Fax: 815-678-6760

2018-2019 Allergy Action Plan

PLACE STUDENT'S PICTURE HERE

Student's Name:_____

Date of Birth:_____ **Teacher/Grade:**_____

ALLERGY TO:_____

Asthmatic: ☐ Yes * ☐ No *Higher risk for severe reaction

TREATMENT

Symptoms:		Give Checked Medication**	
If a food allergen has been ingested (or insect sting), but no Symptoms are present:		☐ EpiPen	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
Skin	Hives, swelling on face or extremities, itchy rash	☐ EpiPen	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epi Pen	☐ Antihistamine
Throat *	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
Lung *	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
Heart *	Thready pulse, low blood pressure, fainting, pale	☐ EpiPen	☐ Antihistamine
Other *	Allow student to self carry medication _____	☐ Epi Pen	☐ Antihistamine

***If a student self carries an EpiPen, parent agrees to keep an additional EpiPen in the Nurse's office.**

MEDICATIONS:

Medication	Dose	Form	Route
Epinephrine	☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3 mg ☐ Twinject 0.15 mg	Auto injector	Inject intramuscularly in the outer thigh
Antihistamine: ☐ Diphenhydramine HCL	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ Other dose _____	Liquid Fast-melt Tablet Thin-Strips	PO
Other Medication:			

EMERGENCY CALLS: **If an Epipen is utilized at school "911"/EMS will be activated**

1. **If EpiPen is given, *call 911*, State a severe allergic reaction and request additional epinephrine. ***Give a new EpiPen* every 15 minutes until ambulance arrives.**
2. **Call Parent/guardian or emergency contact and healthcare provider.**

Name_____ **Ph#**_____ **Ph#**_____
Name_____ **Ph#**_____ **Ph#**_____
Name_____ **Ph#**_____ **Ph#**_____

These orders will be in effect for the current school year

Parent/Guardian's Signature **Date**

Physician Signature (required) **Date**
Address:
Phone #:

NIPPERSINK SCHOOL DISTRICT 2

10006 Main Street
Richmond, IL 60071
* * * * *
Telephone 815-678-4242
FAX 815-678-2810
www.nippersinkdistrict2.org

If you indicated that you child has a food or insect allergy, please fill out and return the attached form to the School Nurse prior to the first day of school.

STUDENT NAME: _____ DOB:_____

Does your child have asthma? YES NO

1) What is your child allergic to?

2) Has your child had allergy testing done? (RAST, food challenge, scratch or other) – if so, what were the results? Please list name and phone number of the Physician who performed testing.

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

4) Please describe the reaction.

5) Was it resolved at the Doctor's office or did it require hospitalization?

6) Was your child prescribed Epinephrine (an Epi-pen)? If yes, when was the last time it was used?

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_____ School Year

Dear Parent or Guardian:

RE: _____
Student name

_____
Date of Birth

You have indicated that your child has an allergy to peanuts or nuts. Our goal is to provide a safe setting for your child during the school day. Our school provides a "peanut free" table should you choose this for your child. Please indicate our wishes below and return to the School Nurse.

_____ YES, my child should be seated at the "peanut free" table for lunch.

_____ NO, my child does not need to be seated at the "peanut free" table for lunch.

_____ _____
Parent Signature Date

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Spring Grove, IL 60081
(815)678-6724 Fax(815)675-0030

MEDICATION AUTHORIZATION

Prescription and Non Prescription medications require both a physician and parent signature in order to be given during school. This form is to be renewed annually.

STUDENT NAME:_____ Grade: _____

DATE OF BIRTH:_____

(PART A-to be completed by the Physician)

MEDICATION _____

DOSAGE _____

TIME of ADMINISTRATION: _____

Reason for medication: _____

Special instructions: _____

Allergies: _____

PHYSICIAN SIGNATURE:_____ PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

DATE:_____

(PART B-to be completed by the parent/guardian)

All medication taken at school must be brought to school in the original medication container and be appropriately labeled by the pharmacy or manufacturer. Prescription medications must indicate student name, the medication name and dose, the time the medication is to be administered and the prescribing physician's name. ALL medication taken at school must be brought to the nurse's office.

I hereby request and grant permission for District #2 School Personnel to dispense medication to my daughter/son,_____ according to the instructions above. I further waive any claims against the School District, its employees and agents arising out of the administration of said medication, and agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the administration of medication. If applicable, I give permission for my child to administer their own asthma or emergency allergy medications.

PARENT/GUARDIAN SIGNATURE:_____DATE: _____

PARENT NAME: _____