

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

2016-2017 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:

If a food allergen has been ingested (or insect sting), but no Symptoms are present:

Mouth Itching, tingling, or swelling of lips, tongue, mouth
Skin Hives, swelling on face or extremities, itchy rash
Gut Nausea, abdominal cramps, vomiting, diarrhea
Throat * Tightening of throat, hoarseness, hacking cough
Lung * Shortness of breath, repetitive coughing, wheezing
Heart * Thready pulse, low blood pressure, fainting, pale
Other * Allow student to self carry medication _____

Give Checked Medication**

<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epi Pen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Epi Pen	<input type="checkbox"/> 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	<input type="checkbox"/> EpiPen <input type="checkbox"/> EpiPen Jr. <input type="checkbox"/> Twinject 0.3 mg <input type="checkbox"/> Twinject 0.15 mg	Auto injector	Inject intramuscularly in the outer thigh
Antihistamine: <input type="checkbox"/> Diphenhydramine HCL	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 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

Dan Oest, Ed.D., Superintendent
Denise Levendoski, Business Manager
Belinda Veillon, Curriculum Director

Paul Augustyn, Richmond Grade School Principal
Tim Molitor, Nippersink Middle School Principal
Chris Pittman, Spring Grove School Principal

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?



NIPPERSINK SCHOOL DISTRICT 2

Richmond Grade School

WHERE EXCELLENCE IS A TRADITION

5815 Broadway
Richmond, IL 60071-0429
Telephone: 815-678-4717 - Fax 815-678-2279

Paul Augustyn, Principal
Dan Oest, Ed, D., Superintendent
Denise Levendoski, Business Manager
District website: nippersinkdistrict2.org

_____ **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

NIPPERSINK DISTRICT 2

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1006 Main Street
Richmond, IL 60071
(815)678-7129 Fax(815)678-7210

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5815 Broadway
Richmond, IL 60071
(815)678-6774 Fax(815)678-2192

Spring Grove Elementary
2018 Main Street
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: _____