ASTHMA, ALLERGY, DIABETES AND FOOD ALLERGY
EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Student Name: _____D.O.B ___ /____ /____

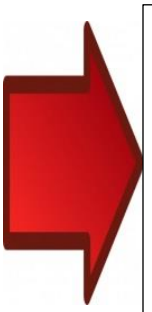
Grade: _____ Weight: _____

Asthma: Yes/No **Allergies: Yes/No** **Food Allergy: Yes/No** **Diabetes: Yes/No**

Allergy to: _____

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheezing, 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, itch rashes, swelling
GUT: Vomiting, crampy pain



INJECTION EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications
- Antihistamine
- Inhaler (bronchodilator) it 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) INJECTION 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 reoccur. 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: Y/N **Student may self-administer epinephrine: Y/N**

CONTACTS: Call 911 Rescue squad: (_____) _____

Parent/Guardian: _____ Ph: (_____) _____

Name/Relationship: _____ Ph: (_____) _____

Name/Relationship: _____ Ph: (_____) _____

Licensed Healthcare Provider Signature: _____

Ph: (_____) _____ 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 protect 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: _____

Exhibit: Authorization to Provide Asthma/Allergy Care/ Diabetes Care
Release of Health Care Information, and Acknowledgement of Responsibilities

I hereby authorize Riverview School District and its employees, as well as any and all Delegated Care Aides named in the Asthma/Allergy/Diabetes Care Plan or later designated by the District, to provide Asthma/Allergy/Diabetes care to my child, _____, consistent with the Asthma/Allergy/Diabetes Care Plan. I authorize the performance of all duties necessary to assist my child with management during school.

I acknowledge that it is my responsibility to ensure that the school is provided with the most up- to-date and complete information regarding my child's asthma/allergies/diabetes treatment. Therefore, I consent to the release of information about my child's asthma/allergies/diabetes and treatment by my child's health care provider(s), _____, [child's health care provider(s)] to representatives of Riverview School District. I further authorize District representatives to communicate directly with the health care provider(s).

I also understand that the information in the Asthma/Allergies/Diabetes Care Plan will be released to appropriate school employees and officials who have responsibility for or contact with my child and who may need to know this information to maintain my child's health and safety.

I acknowledge that the District and District employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with food allergies, environmental allergies, or asthma.

Pursuant to Section 45 of the Care of Students with Diabetes Act, I acknowledge that the District and District employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes.

Parent's Signature: _____ Date: _____

*Failure of Parent(s) to execute this document does not affect the civil immunity afforded the District and school employees by Public Act 96-0349 & the Guidelines for Managing Life-Threatening Food Allergies or Section 45 of the Care of Students with Diabetes Act in Illinois Schools for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes, or any other immunities or defenses to which the District and its employees are otherwise entitled.