Administrative Procedure 5139-APPENDIX A

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SKOKIE SCHOOL DISTRICT 68

Individual Health Care Plan-Allergy/Asthma

Student:_____ Student's weight:_____ Date:_____
Teacher:_____ Grade:_____ School:_____
Home phone:_____

Medical Diagnosis & Brief Medical History:

Medications/Dose: _____

If you should see this:	Do this:

At risk for anaphylaxis: ☐ **YES** ☐**NO**

Epinephrine (Brand and Dose):_____

☐Student may self-carry epinephrine ☐Student may self-administer epinephrine

Check all that apply:

Antihistamine (Brand and Dose): _____

☐Student will carry medication ☐Medication in classroom ☐Medication in Health Office

☐Student will carry Benadryl ☐Benadryl stored in classroom ☐Benadryl in Health Office

Inhaler-bronchodilator (if asthma)_____

☐Student will carry inhaler ☐Inhaler stored in classroom ☐Inhaler in Health Office

Higher risk for a severe reaction: ☐ Yes ☐ No

Medication to travel with student to all school environments during the school day by school personnel

☐ Yes ☐ No

Parent would like to accompany student on field trips ☐ Yes ☐ No

Food handling (each statement must be marked):

Student requires an allergen-free eating area: ☐ Yes ☐ No

Give epinephrine for ANY symptoms if the allergen was likely eaten. ☐ Yes ☐ No

Give epinephrine before symptoms if the allergen was definitely eaten ☐ Yes ☐ No

Student must wash his/her hands with soap & water or cleansing wipe before eating: ☐ Yes ☐ No

Students in classroom should be encouraged to wash their hands upon arrival to school and after eating lunch:

☐ Yes ☐ No

Parent will provide a shelf-stable allergen-free snack that will be available in the classroom if needed:

☐ Yes ☐ No

Emergency Action Plan:

If you see this:	Do this:
MILD SYMPTOMS ONLY Mouth: Itchy mouth Skin: A few hives around mouth/face, mild itch Gut: Mild nausea/discomfort	**GIVE ANTIHISTAMINE** -Stay with student, alert health clerk, child's doctor, and parent
SEVERE SYMPTOMS AFTER SUSPECTED INGESTION: LUNG: Short of breath, wheezing, repetitive cough HEART: Pale, blue skin, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing or swallowing MOUTH: Obstructive tongue or lip swelling SKIN: Many hives over body **COMBINATION OF SYMPTOMS:** SKIN: Hives, itchy rashes, swelling GUT: Vomiting, cramping pain	**INJECT EPHINEPHRINE IMMEDIATELY** - **Call 911** - Begin monitoring: Stay with the student. 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 severe reaction, consider keeping child lying on back with legs raised. Treat student even if parents cannot be reached. - *Dispense Inhaler (bronchodilator) if asthma

Emergency Contacts (Please provide an English speaking adult):

Call 911

Parent/Guardian: _____ Home phone: _____ Cell phone: _____ Work: _____

Name/Relationship: _____ Home phone: _____ Cell phone: _____ Work: _____

Name/Relationship: _____ Home phone: _____ Cell phone: _____ Work: _____

Pursuant to the authority granted under Section 105 ILCS 5/22-30 of the Illinois School Code, I hereby authorize my son/daughter, _____, to self administer asthma medication or use an epinephrine auto-injector at school or during school-sponsored activities while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees, and volunteers from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing in indemnitees and arising out of a claim related directly or indirectly to my son/daughter's self-administration of asthma medication or use of an epinephrine auto-injector, brought by me, any other parent or guardian of my student or another student, or on behalf of my student or another student. I understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of mediation or use of an epinephrine auto-injector, regardless of whether authorization was given by my student's parents or guardians, or by my student's physician, physician's assistant, or advanced practice registered nurse, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

_____ _____

Parent/Guardian signature Date

Copy to: Teacher (emergency & sub folder); Health Clerk; School Evacuation Kit; Cafeteria; Bus Driver; Parent

PARENT	TEACHER'S RESPONSIBILITIES
Parent may decide where the child's emergency medication is kept to include: --The health care office --Classroom --Health care office and classroom	Ensure a student with a suspected allergic reaction is accompanied by an adult at all times.
If emergency medication is kept in the classroom, the medication may need to be transported by school personnel wherever the student travels to within the school environment.	A copy of the student's Health Care Plan will be reviewed with the following personnel and a copy of the plan will be kept in: --classroom emergency folder --sub folder, --school evacuation kit --health care office --special teachers' classrooms --classroom staff Health Care folders (Teacher Assistants etc.) --bus driver Health Care folders (if appropriate) --after school personnel Health Care folders (if appropriate)
Students may require an allergen-free eating area.	Parents will be informed of food limitations in advance of any in-class events where food will be served, to protect the allergic student.
Parent is encouraged to provide a shelf-stable allergen-free snack that will be available in the classroom if needed.	Staff will ensure that food or products containing the student's allergens are not used for class projects, science experiments, or celebrations.
Parent may want to accompany their child on field trips.	If the parent of a student with a food allergy is not attending a field trip, the student will be assigned to a staff member who has been trained to implement the Health Care Plan and is carrying the emergency medication.
Students in the classroom will be encouraged to wash their hands upon arrival to school and after eating lunch.	Field Trip Planning: Oversee cleaning the table of the student with food allergies before eating, ensure the student with the food allergy washes his/her hands before eating, ensure the student with the food allergy eats only allergen-free food or food supplied by the parent, carry a cell phone to call 911 if needed, and review the Health Care Plan before the field trip.

SKOKIE SCHOOL DISTRICT 68

BOARD OF EDUCATION
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SELF ADMINISTRATION OF ASTHMA MEDICATION OR USE OF EPINEPHRINE AUTO-INJECTOR AUTHORIZATION, HOLD-HARMLESS AND INDEMNITY

Student's name: _____

Date of birth: _____

Home Telephone Number _____

Emergency Telephone Number _____

For student use of epinephrine auto-injector (EpiPen), this Section must be completed and signed by either: (i) the student's physician; (ii) physician assistant; or (iii) advanced practice registered nurse:

Licensed Prescriber's Name: _____

Address: _____

Regular Telephone Number: _____

Emergency Telephone Number: _____

Name of EpiPen: _____

Purpose of EpiPen: _____

Dosage: _____

Time and Circumstances of administration at school: _____

Side effects from EpiPen for which student must be observed: _____

_____

_____ _____
Signature of physician, physician's assistant or advanced practice registered nurse — Date

This Section must be completed by the student's parent or guardian:

Pursuant to the authority granted under Section 105 ILCS 5/22-30 of the Illinois School Code, I hereby authorize my son/daughter, _____, to self administer asthma or use an epinephrine auto-injector at school, school-sponsored activities, while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to my son/daughter's self-administration of asthma medication or use of an epinephrine auto-injector of and brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. I understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector, regardless of whether authorization was given by my student's parents or guardians or by my student's physician, physician's assistant, or advanced practice registered nurse, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

_____ _____

Signature of Parent/Guardian Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.