**Vandalia Community Unit School District #203**

**1109 North Eighth Street**

**Vandalia IL 62471**

**Phone 618-283-5151**

Date _____

Dear Parent/Guardian of: _____

The health care forms submitted for your child indicate that he/she has a food allergy. To plan and provide safe care for your child in the school setting, please submit the following enclosed in this packet:

- Allergy History Form
- Illinois Food Allergy Emergency Action Plan and Treatment Authorization
  Must be completed and signed by your child's health care provider and also by the child's parent/guardian.
- Physician Statement for Food Substitution Form if a food accommodation is needed
- Medication Authorization Form
- Authorization for Self Carry/Self Administration of Medicine if applicable

Please submit the above forms along with the medication prescribed (EpiPen, Auvi-Q, Twinject, Adrenalick, etc) by September 1st. The medication and auto injector must be in the original pharmacy container, labeled with the student name and prescription information. You may also submit a picture of your child to be displayed in your child's classroom for recognition if desired.

Enclosed for your review is the school district's policy for food allergies. Please contact the health office if you would like to meet and discuss your child's allergy further and develop a personalized health management plan.

Sincerely,

Joy Lewis, RN, MSN

District School Nurse

Vandalia Community Unit School District #203

School Food Allergy Policy

Implemented 1-1-11

At School Registration:

1. Parents will complete our school district's "Health Information" form.
2. If any food allergies are indicated, parents will be contacted by the nurse.
3. The nurse will give parents a packet regarding what the health office needs from the parents and health care provider in order to provide safe care for their child in the school setting.
4. The nurse will provide the parent/guardian the following items:
    - Allergy History Form
    - Illinois Food Allergy Emergency Action Plan and Treatment Authorization
    - Physician Statement for Food Substitution Form (completed by health care provider if needed)
    - Medication Authorization Form
    - Authorization to Self Carry/Self Administer Medication if applicable

Forms are to be completed by the parent/guardian and health care provider and turned in to the health office by September 1st of the current school year.

After forms are received by the school nurse:

1. Health Concerns list will be distributed to school employees.
2. Original set of copies of the completed forms will be kept in student's health file.
3. Food Service Staff will be given all copies of Physician Statement for Food Substitution forms and individualized Illinois Emergency Food Allergy Action Plans for students in their building.
4. Each school office will be given a folder with copies of the following forms for affected students in that building: health concerns list, Allergy History forms, Physician Statements for Food Substitutions, Food Allergy Emergency Action Plans.
5. Transportation Supervisor will be issued a folder with copies of the above forms for the entire school district. Individual bus drivers will be given pertinent information for students on their bus.

If a food allergy reaction occurs or is suspected:

- Student will be assisted to health office.
- Food Allergy Action Plan will be started.
- School Nurse will be contacted. Nurse will continue to follow the Illinois Emergency Food Allergy Action Plan and observe the student.
- Parent will be notified.
- EMS or local emergency number will be called as needed.

District Employees will have annual training on the following:

1. How to respond to a suspected food allergy reaction.
2. Where the individualized Emergency Food Allergy Action Plans are kept in their building.
3. How to use an EpiPen.

# Vandalia Community Unit School District #203
# Allergy History Form

(Return to School Nurse)

Dear Parent/Guardian of: _____ Date: _____
Grade & Teacher: _____

According to your child's health records, he/she 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 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.

6) Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

Parent or Guardian Signature: _____ Date: _____

Print Name: _____

# 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:** (618 )283-1231

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

**Licensed Healthcare Provider Signature:**_____ Phone:_____ Date:_____
(Required)

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:_____

Vandalia Community Unit School District #203
1109 N. Eighth Street
Vandalia, IL 62471

## Child Nutrition Programs
# PHYSICIAN STATEMENT FOR MEAL ACCOMMODATIONS

| CHILD'S NAME | AGE | DATE |
|---|---|---|
| | | |
| SCHOOL/FACILITY NAME | ADDRESS (Street, City, State, Zip Code) | |
| | | |

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable meal accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact Colleen Reams (*Name*) at 618-283-5155 Ext 272 (*Telephone (Include Area Code)*).

## PHYSICIAN STATEMENT

1. Is this accommodation being requested on the basis of a:
   - ☐ preference
   - ☐ mental or physical impairment or disability according to ADA Amendments of 2008?
     List the impairment or disability: _____
     _____

2. How does this physical or mental impairment restrict the child's diet?

3. What accommodations are being requested? For the safety of the child and because most school/child care centers do not have access to a registered dietician, please be as specific as possible. Attach additional sheet if needed.
   - ☐ Timing of meal service: _____
     _____
   - ☐ Alteration of meal preparation method: _____
     _____
   - ☐ Variation from meal pattern (must include foods to be omitted as well as foods to be substituted; you may attach a menu).
     _____
     _____

4. _____ (*Date*) _____ (*Signature of Physician*) _____ (*Printed Name*)

5. _____ (*Date*) _____ (*Signature of Parent/Guardian*) _____ (*Printed Name*)

**FOR SCHOOL/FACILITY USE ONLY**:
- ☐ Form received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form complete. Accommodations will begin on _____.

_____ (*Date*) _____ (*Signature of Food Service Director/Contact*) _____ (*Printed Name*)

1109 North Eighth Street 618-283-5151

## Vandalia Community Unit School District #203

## SCHOOL MEDICATION AUTHORIZATION FORM

Our district policy and guidance from Illinois State Board of Education states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to administration. No medication will be given during the school day unless absolutely necessary for the critical health and well-being of the student. All medication must be in the original prescription container or manufacturer's package and properly labeled with the student's prescribing information.

**Student Name _____ Date of Birth _____**

**Grade _____ Teacher/Homeroom _____**

**Emergency Name and Phone Number _____**

I hereby authorize Vandalia School District #203 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self-administer) while under the supervision of the employees and agents of the School District, a lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medications to be performed by an individual other than a school nurse, i.e. school administrator, and I consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

_____ _____

**Parent/Guardian Signature** **Date**

---

### TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

**Name of Medication _____**

**Dosage _____ Route_____**

**Duration of Administration _____ Time _____**

**Diagnosis _____**

**Side Effects to be alert to: _____**

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? _____ Yes _____ No

Must this medication be kept with the child at all times? _____ Yes _____ No

Is the child allowed to self carry and self administer this medication (EpiPen, inhaler, insulin)? _____Yes _____ No

**PHYSICIAN NAME (PRINT) _____ DATE _____**

**PHYSICIAN SIGNATURE_____**

**PHYSICIAN ADDRESS_____ PHONE _____**

1109 North Eighth Street 618-283-5151

Vandalia Community Unit School District #203

## SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL

Our school district policy permits a responsible trained student to carry and self-administer medications for asthma, severe allergic (anaphylactic) reaction, or diabetes on his/her person for immediate use in a life-threatening situation with a physician's written authorization, parent consent, and school nurse and principal approvals.

## PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER AUTHORIZATION

Student Name _____ Date of Birth _____

Grade _____ Teacher/Homeroom _____

Condition for which the medication is administered _____

Name of the medication, dosage, and method administered _____

Time or indication for administration _____

Side effects to be alert to: _____

**IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.**

_____

Physician Signature Print Name Telephone Date

## PARENT/GUARDIAN AUTHORIZATION

As the parent/guardian of the above named student, I request that my student be allowed to carry and self-administer the above prescribed medication in school, at any school-sponsored activity, when under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. I further agree that when the medication is so administered, I waive any claims I might have against Vandalia School District #203, its employees, and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. I understand that the medication must be in the original pharmacy container, labeled with the name of the student and all prescribing information.

_____

Parent Signature Relationship Date