URBANA SCHOOL DISTRICT 116

Jean F. Burkholder Administrative Service Center
1101 E. University Ave., Suite B
Urbana, IL 61802
www.usd116.org

URBANA
SCHOOL DISTRICT #116

Dr. Jennifer Ivory-Tatum
Superintendent

Dear Parent/Guardian,

To assist us in the management of your student's allergy/s while at school we will need to have the attached paperwork completed and returned at the beginning of each school year:

- ❑ **ALLERGY ACTION PLAN**
- ❑ **INDIVIDUAL HEALTH CARE PLAN**
- ❑ **SCHOOL MEDICATION AUTHORIZATION FORM(S)**
- ❑ **Authorization for Use & Disclosure of Protected Health Info. & Education Records**
  This form will allow us to contact your child's physician should there be any questions regarding your child's Allergy Action Plan
- ❑ **PHYSICIAN'S STATEMENT FOR MEAL ACCOMMODATIONS**
  Only if your child has food related allergies, this form must be completed by your child's healthcare provider and returned to your child's school each year
- ❑ **Self-Administration of Epinephrine Auto-Injector Authorization Form**
  Only if you and your child's physician agree that your child is capable of carrying and self-administering their epi pen at the appropriate time

Please note the **back** of the **MEDICATION AUTHORIZATION** form for Parent/Guardian responsibilities. Please contact your Building Nurse or the District Nurse at (217)-384-3549 if you have any questions or concerns.

Sincerely, Amy Marx RN | District Nurse

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: (____)_____

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:_____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name:_____ Room:_____

Name:_____ Room:_____

Name:_____ Room:_____

LOCATION OF MEDICATION

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)
414.272.6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital
800.543.7362 (800.KIDS DOC®)
http://www.childrensmemorial.org

Food Allergy Initiative (FAI)
212.207.1974
http://www.faiusa.org

Food Allergy and Anaphylaxis Network (FAAN)
800.929.4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.

Individual Health Care Plan (IHCP)

Life-Threatening Food Allergies

USD #116

ALLERGENS: _____

Student's Name: _____ Date: _____

Teacher: _____ Room: _____

Problem: At risk for Anaphylaxis

Goal: Prevent allergic reactions from occurring and ensure student's safety at school.

Parent: Please answer the questions below:

1. I would like my child's medication kept in: ___ The School Office only
   ___ The Classroom only
   ___ The Office and the Classroom
   ___ Student will carry their Epi-pen

2. Does your child require an **allergen free eating area?** ___ Yes ___ No

3. I would like to accompany my child on field trips. ___ Yes ___ No

4. My child must wash his/her hands with soap and water before eating. ___ Yes ___ No

5. I will provide a shelf-stable allergen free snack that will be available in the classroom if needed. ___ Yes ___ No

6. My child is a bus rider. ___ Yes ___ No

The Individual Health Care Plan has been reviewed and signed by:

Parent Signature: _____ **Date:** _____

(See over)

Individual Health Care Plan (IHCP)

Life-Threatening Food Allergies
USD # 116

Teacher's Responsibilities:

- Ensure the student with a suspected food allergen is under the supervision of an adult at all times.
- Keep a copy of the student's Emergency Action Plan and Individual Health care Plan in the sub folder.
- Inform parents in advance of any in-class events where food will be served.
- Ensure that food or food products containing the allergens are not used for class projects, experiments, or celebrations.
- Coordinate with the parent in advance of field trips to ensure that the student with food allergies eats only allergen free food or food supplied by the parent, carry a communication device to call 911 if needed, and review the Emergency Action Plan before the field trip.
- Implement any accommodations listed on the IHCP by the parent.

Principal Responsibilities:

- Ensure that a communication device is available to playground staff.
- Delegate proper cleaning of the allergen free area in the lunchroom.
- Encourage parents and students to bring healthy snacks to school and avoid snacks made with peanuts or nuts
- Ensure student has an allergen free area in the lunchroom if parent has indicated an allergen free area is needed (see parent section)

District Nurse Responsibilities:

- Provide all staff that interacts with the student information about food allergy symptoms and the steps required to implement the Emergency Action Plan
- A copy of the Emergency Action Plan and Individual Health Care Plan will be distributed on a need to know basis.

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

- USD#116 MEDICATION AUTHORIZATION / RELEASE FORM -

To be completed by Parent/Guardian:

Students Name _____ Birth Date _____

Address _____ School _____

Teacher _____ Grade ____ Home Ph # _____

MEDICATION _____ Emergency Ph # _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Urbana School District #116 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), lawfully prescribed prescription and non-prescription medication in the manner prescribed by our physician/healthcare provider. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. *I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication administration.*

Parent Signature: _____ Date: _____

<u>*TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider*</u>

Medication_____ Dosage _____

Time to be administered _____ Side Effects _____

Effective Date: From: _____ To: _____

Additional Notes:_____

I hereby confirm the schedule for medication administration described above makes it impossible to provide the required dose outside of school hours.

_____ _____ _____

Printed Name of Physician/Healthcare Provider Signature Date

_____ _____ _____

Physician/Healthcare Providers address Phone Number Fax Number

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED CONTAINERS & FOLLOW AGE RECOMMENDATIONS

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

The School District will limit its dispensation of medication to cases where failure to take prescribed medication could jeopardize the students' health and/or education and where it is not possible for a parent to administer the medication and the medication cannot be prescribed in doses scheduled for before and after school hours. *Parent help and consideration is essential for the safety of children who must receive medication while at school.*

1. All medications, including non-prescription drugs, given at school shall be prescribed by a physician. A School Medication Authorization Form must be carefully completed each school year. The physician MUST sign the form and a parent/guardian MUST sign the form.

2. A SEPARATE form is required for each medication.

3. Students are not allowed to carry any medication on their person. EXCEPTIONS will be made for students requiring Asthma medication and/or Epinephrine Auto-Injector providing the appropriate documentation from the physician and parent/guardian is completed and received by the school district.

4. Any change in medication dosage or administration MUST have written authorization from the prescriber.

5. Prescription medication MUST be sent in the original container with: students name, name of medication, dosage, schedule of administration, expiration date, prescribers name.

6. Non-Prescription medication MUST be sent in the original container and MUST be age appropriate for the student taking them. A Medication Authorization Form MUST be completed for non-prescription medications.

7. **NO MEDICATIONS WILL BE GIVEN AT SCHOOL UNLESS THE ABOVE GUIDELINES ARE MET**

8. All prescription and non prescription medications MUST be taken to the school office by the parent/guardian where it will be kept in a locked space. EXCEPTIONS will be made for Asthma medication and/or Epinephrine Auto-Injectors (see #3 above).

9. **Please talk with your physician about scheduling medications to avoid school hours whenever possible. Prescription medications which are to be taken 3 times a day normally do not need to be given at school.*

10. It is the parent/guardian's responsibility to pick up all unused medications before the last day of school. Any medication left at school will be disposed of properly by the nurse. We cannot send medication home with students (unless it is an authorized Self-Carry medication).

11. *Please take into consideration if your child will be attending a summer school program and may still need medication while at school, in which case the medication can be left at school at the end of the school year. Please work with your Building Nurse on how the medication will be administered during the summer school program.*

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

- USD#116 MEDICATION AUTHORIZATION / RELEASE FORM -

To be completed by Parent/Guardian:

Students Name _____ Birth Date _____

Address _____ School _____

Teacher _____ Grade ____ Home Ph # _____

MEDICATION _____ Emergency Ph # _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Urbana School District #116 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), lawfully prescribed prescription and non-prescription medication in the manner prescribed by our physician/healthcare provider. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. *I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication administration.*

Parent Signature: _____ Date: _____

<u>*TO BE COMPLETED BY THE STUDENT'S Physician/Healthcare Provider*</u>

Medication_____ Dosage _____

Time to be administered _____ Side Effects _____

Effective Date: From: _____ To: _____

Additional Notes:_____

I hereby confirm the schedule for medication administration described above makes it impossible to provide the required dose outside of school hours.

_____ _____ _____

Printed Name of Physician/Healthcare Provider Signature Date

_____ _____ _____

Physician/Healthcare Providers address Phone Number Fax Number

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED CONTAINERS & FOLLOW AGE RECOMMENDATIONS

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

The School District will limit its dispensation of medication to cases where failure to take prescribed medication could jeopardize the students' health and/or education and where it is not possible for a parent to administer the medication and the medication cannot be prescribed in doses scheduled for before and after school hours. *Parent help and consideration is essential for the safety of children who must receive medication while at school.*

1. All medications, including non-prescription drugs, given at school shall be prescribed by a physician. A School Medication Authorization Form must be carefully completed each school year. The physician MUST sign the form and a parent/guardian MUST sign the form.

2. A SEPARATE form is required for each medication.

3. Students are not allowed to carry any medication on their person. EXCEPTIONS will be made for students requiring Asthma medication and/or Epinephrine Auto-Injector providing the appropriate documentation from the physician and parent/guardian is completed and received by the school district.

4. Any change in medication dosage or administration MUST have written authorization from the prescriber.

5. Prescription medication MUST be sent in the original container with: students name, name of medication, dosage, schedule of administration, expiration date, prescribers name.

6. Non-Prescription medication MUST be sent in the original container and MUST be age appropriate for the student taking them. A Medication Authorization Form MUST be completed for non-prescription medications.

7. **NO MEDICATIONS WILL BE GIVEN AT SCHOOL UNLESS THE ABOVE GUIDELINES ARE MET**

8. All prescription and non prescription medications MUST be taken to the school office by the parent/guardian where it will be kept in a locked space. EXCEPTIONS will be made for Asthma medication and/or Epinephrine Auto-Injectors (see #3 above).

9. **Please talk with your physician about scheduling medications to avoid school hours whenever possible. Prescription medications which are to be taken 3 times a day normally do not need to be given at school.*

10. It is the parent/guardian's responsibility to pick up all unused medications before the last day of school. Any medication left at school will be disposed of properly by the nurse. We cannot send medication home with students (unless it is an authorized Self-Carry medication).

11. *Please take into consideration if your child will be attending a summer school program and may still need medication while at school, in which case the medication can be left at school at the end of the school year. Please work with your Building Nurse on how the medication will be administered during the summer school program.*

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana IL 61802
217-384-3600

Authorization for Use and Disclosure of Protected Health Information and Education Records

Patient/Student Name: _____ **Date of Birth:** _____

I hereby authorize: _____
_____
_____

to disclose protected health information and/or educational records to:

_____
_____
_____

_____ Check here if authorization is given for the parties listed above to mutually exchange the information described below.

Description:

The health information to be disclosed consists of (check all that apply):

_____ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records. (Cross out any item that you do not authorize to be released)
_____ Records regarding treatment for the following condition or injury _____
_____ Records covering the period of time between _____ and _____
_____ Other (be specific, including dates) _____

The education information to be disclosed consists of (check all that apply):

_____ Any and all educational records, including special education records
_____ Records covering the period of time between _____ and _____
_____ Other _____

Purpose: This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply)

_____ Educational evaluation and program planning
_____ Health assessment and planning for health care services and treatment in school
_____ Medical evaluation and treatment
_____ Other _____

This authorization is valid for one calendar year and will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents.

Parent Signature _____ Date _____

Student Signature* _____ Date _____

*student signature required if the minor student is over age 12 and if this authorization is for the release of mental health records

Urbana School District #116

Is Student in Before School Program Yes or No
Is Student in After School Program Yes or No

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 Johnathan Schmit (*Name*) at 217-384-3501 (*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*)

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana, IL 61802
217-384-3600

- SELF-ADMINISTRATION OF EPINEPHRINE AUTO-INJECTOR AUTHORIZATION FORM -

To be completed by Parent/Guardian:

Student's Name _____ Date of Birth_____

Address _____ Home Phone _____

School _____ Grade_____ Emergency Phone _____

As parent or guardian of the above-named student, I acknowledge that Urbana School District #116 and its employees and agents are to incur no liability except for willful and wanton conduct as a result of injury arising from the self-administration or carrying of an epinephrine auto-injector by my child. I indemnify and hold harmless the school district, its employees and agents against any claims, except a claim based on willful and wanton conduct arising out of the self-administration or carrying of an epinephrine auto-injector by my child. I will notify the school of changes in the medication or in my child's condition.

Parent Signature _____ Date _____

TO BE COMPLETED BY STUDENT'S PHYSICIAN/PHYSICIAN ASSISTANT/ADVANCED PRACTICE NURSE:

I am requesting the above-named student be allowed to self-administer the following epinephrine auto-injector during school hours.

Medication _____ Dosage _____

Time(s) to be given _____ Possible side effects _____

Effective date – From:_____ To:_____

As a health care provider for the above-named student, I certify that the child has been instructed in the use and self-administration of the above-named medication and the necessity to report to school personnel any unusual side effects. The child is capable of using this medication independently.

_____ _____

Name of Physician, Physician Assistant, or Advanced Practice Nurse (Print) Signature/Date

_____

Phone # of Physician, Physician Assistant, or Advanced Practice Nurse

Urbana School District #116
1101 E. University Avenue, Suite B, Urbana, IL 61802
217-384-3600

SCHOOL SELF-ADMINSTRATION OF EPINEPHRINE AUTO-INJECTOR GUIDELINES

The parent/guardian and physician, physician assistant, or advanced practice nurse may request a student be allowed to carry and self-administer their epinephrine auto-injector while at school.

Parent help and consideration is essential in providing for the safety of all students attending school.

1) The epinephrine auto-injector must be prescribed by a physician, physician assistant, or nurse practitioner authorized to prescribe such medication.

2) Medication should be sent in a correctly labeled prescription container.

3) A school epinephrine auto-injector self-administration authorization form must be completed by the physician, physician assistant, or advanced practice nurse and parent or guardian.

4) Parents are responsible for notifying the school of any changes in the medication or in their child's condition.

5) It is recommended an additional dose of the epinephrine auto-injector be kept at the school for the child's protection in case they have misplaced or forgotten their medication.

6) The permission for self-administration of medication is effective for **ONLY** the school year during which it is granted.

7) A student may possess his/her epinephrine auto-injector while in school, at a school sponsored activity, while under the supervision of school personnel or before or after school activities such as while in before or after school care on school operated property.

Please contact the the Building Nurse or the District Nurse Ph # 384-3549 if you have any questions.