Lockport Township High School District 205

Dr. Robert McBride, Jr., Superintendent
815.588.8100

Lorie Cristofaro, M.S.Ed, NBCT, Assistant Superintendent
Curriculum and Instruction
815.588.8102

Anthony J. Cundari., Assistant Superintendent
Personnel
815.588.8103

Stefanie L. Croix, Director of Business Services/CSBO
815.588.8110 Fax: 815.588.8119

William J. Thompson, Director of Facilities Management/CSBO
815.588.8116 Fax: 815.588.8119

Dear Parents or Guardians,

Public Act 96-0349 of the Illinois School Code provides guidelines for school district management of life-threatening food allergies.

Lockport Township High School has created a Food Allergy Management Plan which can be found on our website. Packets are being sent home to the parents/guardians of students/children with known food allergies to be completed. The school nurse will then assemble a teacher reference packet and disseminate it to the appropriate staff. In the cafeteria a "peanut free zone" has been created and will be properly maintained by our custodial staff.

Food allergies present an increasing challenge for schools. Identification of students at risk of a life-threatening reaction cannot be predicted. Because of the life-threatening nature of these allergies and their increasing prevalence, school districts and individual schools must be prepared to provide treatment to food-allergic students, reduce the risk of a food-allergic reaction and to accommodate students with food allergies.

Please take a moment to read over the Emergency Action Plan, and medication authorization form. This will provide us with more information about your child's health needs.

Thank you for your cooperation in this matter,

Mrs. D. Koran, R.N.

School Nurse
District 205 Central Campus
1222 S. Jefferson St
Lockport, IL 60441
dkoran@lths.org
P 815-588-8280
F 815-588-8279

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:_____

LOCKPORT TOWNSHIP HIGH SCHOOL
DISTRICT 205
ADMINISTERING MEDICATION TO STUDENTS

Section I
Prescription Medication

Medication required by a student shall generally not be administered at school by a District employee. This policy includes even common and widely used over-the-counter preparations.

However, students recovering from temporary illness or students on permanent medication who require medication during the school day may bring medication to school following these guidelines:

1. A written statement from the student's physician, indicating the necessity for the medication along with the medication name and dosage, administration route and /or other direction, licensed prescriber's name, pharmacy name, address and telephone number.
2. A written request for permission to administer the medication along with a written release of liability from the parent(s)/guardian(s) shall be required.
3. Medication shall be brought to school in appropriately labeled containers. The name of the student and the names and phone numbers of the physician and pharmacy shall be indicated on the containers.

Prescription medication shall be administered by the school nurse or other designated personnel.

All prescription medication with the exception of inhalers will kept in a locked drawer or cabinet.

Section II
Non-prescription Medication

District 205 follows the state guidelines for medication administration. This means that students are responsible for their own over-the-counter medication such as Tylenol, Midol, aspirin, etc., as long as they have a written mediation authorization from their parent or guardian on file in the nurse's office for all non-prescription medication that they bring to school. No non-prescription medication will be supplied at any time to any student by District 205 employees. Non-prescription over-the-counter medication must be taken in the nurse's office under adult supervision. All medication should be in its original container and labeled with the student's name. No loose pills or capsules are to be carried by the student in school. **Under no circumstances** are students to share their medication with one another.

Each student must take responsibility for understanding the medication he/she is taking. He/she should be able to verbally articulate the medication name and dosage, the route taken, why it is needed and its possible side effects as well as how many hours are needed between each dose.

No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

In all cases the school retains the discretion to reject a request for administering medication.

Revised: April 23, 2003

LOCKPORT TOWNSHIP HIGH SCHOOL DISTRICT 205

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Name:_____ Date of Birth:_____

Physician's Orders: (to be filled out by the **ATTENDING DOCTOR**—PLEASE PRINT)

_____ _____
Name of Medication Dosage

_____ _____
Time Route

_____ _____
Prescription Date Expected Discontinuation Date

_____
Reason for prescribing medication during school hours

_____
Time interval for re-evaluation

_____
Possible side effects of medication:

PHYSICIAN'S SIGNATURE:_____

Address:_____

Phone Number:_____ Date:_____

Parent Authorization

I hereby authorize _____ to take the medication as prescribed above. Prescription medication, except for inhalers, will be kept in the nurse's office. All prescription drugs shall be prescribed by an Illinois licensed physician or dentist. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other that a school nurse and specifically consent to such practices. 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 School District 205, 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 or attempts at administration of said medication, including the self-administration of inhalers and M.D. ordered non-prescription medications.

_____ _____
Parent/Guardian Signature Home/Work/Cell Phone Numbers

_____
Address

_____
Emergency Number

mjd
05/07/03

LOCKPORT TOWNSHIP HIGH SCHOOL DISTRICT 205

NON-PRESCRIPTION MEDICATION AUTHORIZATION FORM

Name:_____ Date of Birth:_____

Address:_____

City and State:_____ Zip:_____

Telephone Number:_____

Parent Authorization

I am requesting that my son/daughter take the following over-the-counter medication that I have supplied during school hours.

_____ _____
Name of Medication Type (tablet, liquid, or capsule)

_____ _____
Dosage Time Interval Between Doses (how often)

_____
Possible Side Effects

I certify that _____ has been instructed in the use and self-
Name of Student
administration of _____.
Name of Medication

He/she understands the reason for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this non-prescription medication in the presence of an adult in the nurse's office.

I acknowledge that it may be necessary for my son/daughter to take non-prescription (over-the-counter) medication during school hours. I further acknowledge and agree that, he/she is capable of carrying this non-prescription medication, and I waive any claims I might have against School District 205, its employees and agents, arising out of the self-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 self-administration of said medication in the presence of an adult in the nurse's office.

I may be reached at the following phone numbers in the event of a reaction to the medication or in case of an emergency:

_____ _____
Parent/Guardian Signature Home/Work/Cell Phone Numbers

mjd
05/07/03