



Christian Liberty Academy
 502 W. Euclid Avenue, Arlington Heights, Illinois 60004
 (847) 259-4444 FAX (847) 259-9972



FOOD ALLERGY HEALTH CARE PLAN

STUDENT NAME: _____ D.O.B. _____ GRADE: _____

A review of the health information you completed indicated that your child has **FOOD ALLERGIES**. In order for us to meet his/her health and safety needs in the school environment, it is important that you provide the following information. Please complete carefully, accurately, and completely. We will utilize this information in planning for and responding to any needs that become apparent during school hours.

Treating Physician's name: _____ Phone: _____

Date of last exam for this condition: _____ Age at which Food Allergies diagnosed: _____

LIST THE **FOODS** THAT TRIGGER YOUR CHILD'S **ALLERGIES**: _____

LIST THE SYMPTOMS YOUR CHILD MANIFESTS WHEN EXPOSED TO THE **ALLERGEN**: _____

Does your child have an Epi-pen? Yes No Stored In school Office? Yes No
 With the Teacher for field trips? Yes No

IF MEDICATION IS REQUIRED AT SCHOOL, (EPI-PEN OR OTHER ALLERGY MEDICATION), A SIGNED PRESCRIPTION MEDICATION FORM IS REQUIRED FOR EACH MEDICATION.

PROTOCOL:

1. IF STUDENT EXHIBITS MILD SYMPTOMS, (SEVERAL HIVES, ITCHY SKIN) **OR** IF AN INGESTION IS SUSPECTED
 - STUDENT WILL BE SENT TO THE OFFICE
 - PARENTS WILL BE CONTACTED
 - STUDENT WILL BE OBSERVED FOR MORE SERIOUS SYMPTOMS

2. STUDENT WILL BE OBSERVED AND IF SYMPTOMS PROGRESS TO A LIFE-THREATENING REACTION SUCH AS:
 - a. HIVES SPREADING OVER THE BODY
 - b. STUDENT IS WHEEZING OR HAS DIFFICULTY BREATHING OR SWALLOWING
 - c. STUDENT HAS SWELLING OF THE FACE OR NECK
 - d. STUDENT HAS TINGLING OF THE TONGUE
 - e. STUDENT HAS SIGNS OF SHOCK (EXTREME PALENESS, GRAY COLOR, OR CLAMMY SKIN), **THEN**

3. THE EMERGENCY RESPONSE WILL BE:
 - GIVE EPI-PEN IMMEDIATELY, PLACE AGAINST UPPER THIGH, THROUGH CLOSING IF NECESSARY
 - CALL 911 IMMEDIATELY
 - CONTACT PARENTS OR EMERGENCY CONTACT
 - DISCARD EPI-PEN TO EMERGENCY RESPONDERS
 -

Indicate additional treatments you would like Christian Liberty Academy to administer in treating your child's Food Allergy? _____

I give permission for this information to be shared with adults at Christian Liberty Academy on a need to know basis. *This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Nurse's Office whenever there is a change in my child's health status or care.*

 Parent/Guardian Signature

Dated: _____

 Signature of Health Care Provider with Prescriptive Authority

 License Number of Health Care Provider

 Printed Name of Health Care Provider

 Phone Number

Dated: _____