

## Allergy/ Intolerance Form

Student Name:

Completed by:

School:

Relationship to student:

If we have further questions about this allergy how can we contact you:

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Please provide as much detail as possible when completing this form. An allergy is an immune system response to a substance known as an *Allergen*. For example, allergens can be foods, insects, medication and plants. A food intolerance is an unpleasant digestive response to a food.

**Please list any known allergies:**

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**What is the student's reaction to the allergen(s)?** (For each one, please give as much detail as possible)

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**What treatment should be provided if the child is exposed to the allergen?**

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*Any Epi- pens, inhalers or emergency medication will be the responsibility of the school. Chaperones must know the location of Epi- pens, inhalers, or emergency medications at all times.*

**If the allergen is food, what would be the student's reaction if they:**

*— Please complete  
Food Allergy packet*

- Touched the food: \_\_\_\_\_  
\_\_\_\_\_
- Ingested the food: \_\_\_\_\_  
\_\_\_\_\_
- Ate items processed in the same factory as the allergen: \_\_\_\_\_  
\_\_\_\_\_

**Please list any known food intolerances and provide information as to how the intolerance is managed.**

*on food packet*

*Non-food allergies*



RED BUD SCHOOL DISTRICT #132  
SELF ADMINISTRATION OF MEDICATION-EPIPEN

DATE \_\_\_\_\_ NAME \_\_\_\_\_  
MEDICATION \_\_\_\_\_  
DOSE \_\_\_\_\_ FREQUENCY \_\_\_\_\_

Public Act 92-0402 allows public school students with asthma/severe allergies to carry and self-administer prescribed asthma and/or epinephrine auto-injector devices. State law requires the school district to inform the parents or guardians of the student, in writing, that the school district and its employees and agents are to incur no liability, except for willing and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

Prior to allowing your child to carry and self-administer the medication, a copy of this form must be signed by the parent or guardian and returned to the child's school nurse.

The permission for self-administration of asthma/severe allergy medication is effective for the school year for which it is granted. It shall be renewed each school year as required for health purposes. This student may possess and use his/her medication while in school, at school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities. The district recommends you provide an additional dose of medication to be kept at school in the event your child forgets or misplaces his/her medication.

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As parent or guardian of \_\_\_\_\_, I  
acknowledge that Red Bud School District #132 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. I indemnify and hold harmless the school district and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student. I believe this child to be knowledgeable and capable to self-administer this medication without supervision.

PARENT

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ALONG WITH THIS FORM THE ATTACHED MEDICATION FORM  
AND ACTION PLAN MUST BE COMPLETED**



PLACE  
PICTURE  
HERE

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

Extremely reactive to the following foods/for products:

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**



**LUNG**

Short of breath, wheezing, repetitive cough



**HEART**

Pale, blue, faint, weak pulse, dizzy



**THROAT**

Tight, hoarse, trouble breathing/ swallowing



**MOUTH**

Significant swelling of the tongue and/or lips



**SKIN**

any hives over dy, widespread redness



**GUT**

Repetitive vomiting, severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.



**INJECT EPINEPHRINE IMMEDIATELY.**

Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

Consider giving additional medications following epinephrine:

- » Antihistamine
- » Inhaler (bronchodilator) if wheezing

Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.

If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.

Alert emergency contacts.

Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS**



**NOSE**

Itchy/runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

/GUARDIAN AUTHORIZATION SIGNATURE

DATE

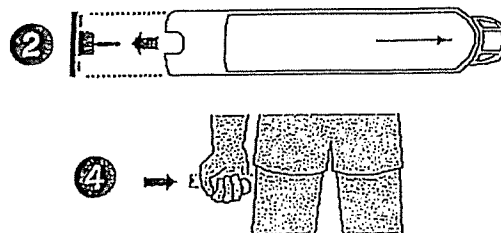
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



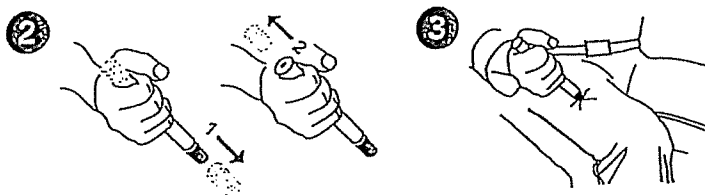
### EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



### ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

\_\_\_\_\_  
PARENT/GUARDIAN AUTHORIZATION SIGNATURE

\_\_\_\_\_  
DATE