ST. TERESA CATHOLIC SCHOOL
1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

Since your child has food allergies, these forms are being provided for you to take to your doctor to be completed. If additional copies of medication forms are needed, you may print them from the St. Teresa website.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse
St. Teresa School

Food Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

Give Checked Medication:**
(To be determined by physician authorizing treatment)

▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪	Mouth — Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪	Skin — Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪	Gut — Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪	Throat† — Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪	Lung† — Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪	Heart† — Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪	Other† _____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephri may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

ST. TERESA CATHOLIC SCHOOL
1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

If your child requires ***any*** medications while at school, medication forms **must** be completed by your child's physician and on file at the school office. Please make copies of the forms provided if you have more than one child requiring medication at school or your child needs more than one medication. This includes both prescription medications as well as non-prescription (Tylenol, Motrin, Benadryl, eye drops, etc.) medications. For inhaler use at school, a separate form is included. For that form, only a parent signature is necessary, but a medication form completed by the physician must also be submitted before the medication can be administered at school.

Please, take these forms with you for the doctor to complete. These forms must be re-submitted on a yearly basis. Please advise the nurse if your child requires an additional "allergy packet" to be provided.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse
St. Teresa School

ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

SCHOOL MEDICATION AUTHORIZATION FORM

Student Name (printed) _____ Grade _____

Any student who is REQUIRED to take medication of any kind during the school day may be assisted by the school nurse or other designated school personnel if the school has received the following:

1. A written statement from the physician detailing the method, amount, and time the medication is to be taken,
2. A written statement from the parent/guardian requesting the school to assist the pupil in the manner set forth by the physician statement, and
3. The medication shall be in a properly labeled pharmacy bottle.

A new form must be completed for all medication changes, or if the medication is discontinued sooner than stated below. All medication must be kept in and dispensed from the nurses' office.

PHYSICIAN STATEMENT

Student Name (printed) _____ Grade _____ Date _____

Name of Medication _____

Dosage _____ Time of Administration _____

Method of Administration _____ Date to Discontinue _____

Predictable Side Effects _____

Contraindications _____

Physician's Signature _____ Telephone Number _____

Street Address: _____

City: _____ State: _____ Zip: _____

PARENT OR GUARDIAN STATEMENT

As the parent/guardian of the above named student, I request St. Teresa School to assist in carrying out the physician's instructions in the administration of the above named medication during the school day. I further agree that when the medication is so administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school, 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 have read the policy and procedures for administration of medication at St. Teresa School and agree to abide by them.

Parent Signature: _____

Parent Name (printed): _____

Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please return this form to the school office, signed by the physician and the parent/guardian.

NO MEDICATION (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ADMINISTRED WITHOUT REQUIRED SIGNATURE

ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICINE

I, _____ or we, _____ and _____, parents or guardians of _____ (hereinafter "Student"), a student at _____ School (hereinafter "School") hereby request and authorize School to permit Student to self-administer asthma medication prescribed by the Student's physician, physician assistant, or advanced practice registered nurse, which is described more fully in a written statement provided by the Student's physician, physician assistant, or advanced practice registered nurse, which has been given or will be given shortly to the School. We (I) understand that this authorization will not be effective and the School cannot act upon it until the School has received the above described written statement from the Student's physician, physician assistant, or advanced practice registered nurse.

We (I) understand and acknowledge that the School, the Parish of which it is a part, their agents and employees, the Diocese of Belleville, the Bishop of Belleville are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from self-administration of medication by Student.

We (I) hold harmless and indemnify the School, the Parish of which it is a part, their agents and employees, the Diocese of Belleville, the Bishop of Belleville against any and all claims except based on willful and wanton conduct, arising out of self-administration of medication by the Student.

We (I) understand that any abuse of this right by the Student or any endangerment of another student or students by means of the Student's possession of this medication may result in appropriate disciplinary action under our discipline policy.

This authorization is effective only the school year _____ - _____.

Parent/Guardian Signature: _____

Parent/Guardian (printed): _____

Date: _____

Parent/Guardian Signature: _____

Parent/Guardian (printed): _____

Date: _____

ST. TERESA CATHOLIC SCHOOL
1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

As part of the paperwork required for your student with allergies, the state of Illinois requires a physician statement for food substitution. Since our food is provided by District 118, that information is listed at the top of the form. You are receiving this letter so that you may have your child's doctor completed this form prior to the new school year.

Please submit this to our office as soon as possible. Our fax number is 235-7930.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse
St. Teresa School

Belleville School District #118
105 West A Street
Belleville, IL 62220

Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

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 food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food 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 _____ at _____.
Name *Telephone (Include Area Code)*

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? *(Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*
   - ☐ No — **If no, go to item 2 below.**
   - ☐ Yes — **If yes, provide the following information and complete items 3, 4, and 5 below.**
     - a. What is the disability? _____
     - b. What major life activity is affected? _____
     - c. How does the disability restrict the diet? _____
2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.
3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
5. _____ _____
   Date *Signature of Physician*

FOR OFFICE 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*

ISBE 67-48 (1/12)