



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

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 allergens: _____

THEREFORE:

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

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, 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.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or 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 or Generic: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

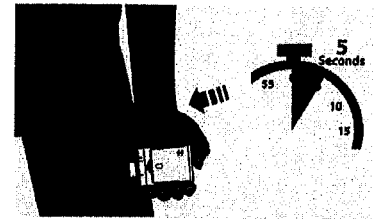
Other (e.g., inhaler-bronchodilator if wheezing): _____



HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.

3



HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

3



4



HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

3



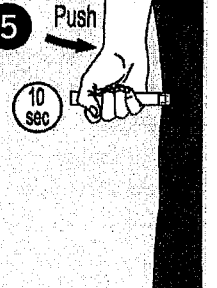
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HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

5



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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 worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____



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



**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 _____ at _____
Telephone (Include Area Code) *Name*

PHYSICIAN STATEMENT

- 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: _____

- How does this physical or mental impairment restrict the child's diet?
- 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).

- _____
Date *Signature of Physician* *Printed Name*
- _____
Date *Signature of Parent/Guardian* *Printed Name*

FOR SCHOOL/FACILITY USE ONLY:		
<input type="checkbox"/> Form received on _____.		
<input type="checkbox"/> Form incomplete. Parent contacted on _____.		
<input type="checkbox"/> Form complete. Accommodation will not be made.	<input type="checkbox"/> Child does not have a disability	<input type="checkbox"/> Request not reasonable
<input type="checkbox"/> Form complete. Accommodations will begin on _____.		
_____ <i>Date</i>	_____ <i>Signature of Food Service Director/Contact</i>	_____ <i>Printed Name</i>



ST. TERESA CATHOLIC SCHOOL
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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



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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**



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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: _____