Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Allergy

Packet

Paquete de Alergia

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

SCHOOL GUIDELINES FOR MANAGING STUDENTS WITH FOOD ALLERGIES

Food allergies can be life threatening. The risk of accidental exposure to foods can be reduced in the school setting if schools work with students, parents, and physicians to minimize risks and provide a safe educational environment for food-allergic students.

Family's Responsibility

- Notify the school of the child's allergies.
- Work with the school team to develop a plan that accommodates the child's needs throughout the school including in the classroom, in the cafeteria, in after-care programs, during school-sponsored activities, and on the school bus, as well as a Food Allergy Action Plan.
- Provide written medical documentation, instructions, and medications as directed by a physician, using the Food Allergy Action Plan as a guide. Include a photo of the child on written form.
- Provide properly labeled medications and replace medications after use or upon expiration.
- Educate the child in the self-management of their food allergy including:
    - **safe and unsafe foods**
    - **strategies for avoiding exposure to unsafe foods**
    - **symptoms of allergic reactions**
    - **how and when to tell an adult they may be having an allergy-related problem**
    - **how to read food labels (age appropriate)**
- Review policies/procedures with the school staff, the child's physician, and the child (if age appropriate) after a reaction has occurred.
- Provide emergency contact information

Student's Responsibility

- Should not trade food with others.
- Should not eat anything with unknown ingredients or known to contain any allergen.
- Should be proactive in the care and management of their food allergies and reactions based on their developmental level.
- Should notify an adult immediately if they eat something they believe may contain the food to which they are allergic.
- More detailed suggestions for implementing these objectives and creating a specific plan for each individual student in order to address his or her particular needs are available in The Food Allergy & Anaphylaxis Network's (FAAN) School Food Allergy Program. The School Food Allergy Program has been endorsed and/or supported by the Anaphylaxis Committee of the American Academy of Allergy Asthma and Immunology, the National Association of School Nurses, and the Executive Committee of the Section on Allergy and Immunology of the American Academy of Pediatrics. FAAN can be reached at: 800/929-4040.

The following organizations participated in the development of this document:
American School Food Service Association
National Association of Elementary School Principals
National Association of School Nurses
National School Boards Association
The Food Allergy & Anaphylaxis Network

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

DIRECTRICES ESCOLARES PARA CONTROLAR LAS ALERGIAS ALIMENTICIAS DE LOS ESTUDIANTES

Las alergias alimenticias pueden ser mortales. El riesgo de una exposición accidental a los alimentos puede reducirse en un entorno escolar si las escuelas trabajan con los estudiantes, padres y médicos para minimizar los riesgos y proporcionar un ambiente educativo seguro para los estudiantes que tengan alergia a los alimentos.

La Responsabilidad de la Familia

- Notificar a la escuela sobre las alergias del niño(a).
- Trabajar con el equipo de la escuela para desarrollar un plan que se ajuste a las necesidades del niño(a) en toda la escuela, incluso en el salón, en la cafetería, en los programas de cuidado posterior, durante las actividades patrocinadas por la escuela y en el autobús escolar, así como un Plan de acción para la alergia de comidas.
- Proporcione documentación médica por escrita, instrucciones y medicamentos según las indicaciones de un médico, utilizando el Plan de acción para las alergias de comida como guía. Incluya una foto del niño(a) en forma escrita.
- Proporcione medicamentos debidamente etiquetados y reemplace los medicamentos después de su uso o cuando se venza.
- Educar al niño(a) en el autocontrol de su alergia alimentaria, incluyendo:
  - **alimentos seguros e inseguros**
  - **estrategias para evitar la exposición a alimentos inseguros**
  - **síntomas de reacciones alérgicas**
  - **como y cuando decirle a un adulto que talvez está teniendo un problema relacionado con la alergia**
  - **como leer las etiquetas de los alimentos (apropiadas a su edad)**
- Revise las pólizas /procedimientos con el personal de la escuela, el médico del niño(a) y el niño (si la edad es apropiada) después de que se haya producido una reacción.
- Proporcionar información de contacto de emergencia.

Responsabilidad del Estudiante

- No debe intercambiar alimentos con otros.
- No debe comer nada con ingredientes desconocidos o que se sepa que contienen alérgenos.
- Debe ser proactivo en el cuidado y manejo de sus alergias a los alimentos y reacciones basadas en su nivel de desarrollo.
- Debe notificar a un adulto inmediatamente si come algo que cree que puede contener los alimentos a los que es alérgico(a).
- Las sugerencias más detalladas para implementar estos objetivos y crear un plan específico para cada estudiante individual con el fin de abordar sus necesidades particulares están disponibles en la Alergia Alimenticia y de la Red de Anafilaxia (FAAN) el Programa de Alergia Alimenticia Escolar. El Programa de la Alergia Alimenticia Escolar ha sido respaldado y/o apoyado por el Comité de Anafilaxia de la Academia Americana de Alergia, Asma e Inmunología, la Asociación Nacional de Enfermeras Escolares y el Comité Ejecutivo de la Sección de Alergia e Inmunología de la Academia Americana de Pediatría. Puede comunicarse con FAAN al: 800 / 929-4040.

Las siguientes organizaciones participaron en el desarrollo de este documento:
Asociación Americana de Servicio Alimenticios Escolares
Asociación Nacional de Directores de las Escuelas Primarias
Asociación Nacional de las Enfermeras Escolares
Asociación Nacional de las Juntas Escolares
La Alergia Alimenticia y la Red de Anafilaxia

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Accommodating Children with Special Dietary Needs

The U.S. Department of Agriculture's (USDA) nondiscrimination regulation (7 CFR 15b), as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to the regular meal must be made for children who are unable to eat school meals because of their disabilities, when that need is certified by a licensed physician.

Physician's Statement for Children with Disabilities

USDA regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. The physician's statement must identify:

- the child's disability;
- an explanation of why the disability restricts the child's diet;
- the major life activity affected by the disability;
- the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

For children with disabilities who only require modifications in texture (such as chopped, ground or pureed foods), a licensed physician's written instructions indicating the appropriate food texture is recommended, but not required.

Medical Statement for Children with Special Dietary Needs

Each special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority. The medical statement must include:

- an identification of the medical or other special dietary condition which restricts the child's diet;
- the food or foods to be omitted from the child's diet; and
- the food or choice of foods to be substituted.

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Acomodando a Niños(as) con Necesidades Dietéticas Especiales

La regulación de no discriminación del Departamento de Agricultura de los Estados Unidos (USDA, por sus siglas en inglés) (7 CFR 15b), así como los reglamentos que rigen el Programa Nacional de Almuerzos Escolares y el Programa de Desayuno Escolar, dejan en claro que las sustituciones de la comida regular deberán hacerse para los niños que no puedan comer comidas escolares debido a sus discapacidades, cuando esa necesidad está certificada por un médico con licencia.

Declaración del Médico para Niños(as) con Discapacidades

Las regulaciones del USDA 7 CFR Parte 15b requieren sustituciones o modificaciones en las comidas escolares para niños(as) cuyas discapacidades restringen sus dietas. Un niño(a) con una discapacidad debe recibir sustituciones en los alimentos cuando esa necesidad esté respaldada por una declaración firmada por un médico con licencia. La declaración del médico debe identificar:

- la discapacidad del niño(a);
- una explicación de por qué la discapacidad restringe la dieta del niño(a);
- la principal actividad vital afectada por la discapacidad;
- la comida o los alimentos que deben omitirse de la dieta del niño(a), y la comida o la elección de los alimentos que deben ser sustituidos.

Para los niños con discapacidades que solo requieren modificaciones en la textura (como alimentos picados, molidos o en puré), se recomienda, pero no se requiere, instrucciones escritas de un médico con licencia que indiquen la textura adecuada de los alimentos.

Declaración Médica para Niños(as) con Necesidades Dietéticas Especiales

Cada solicitud dietética especial debe estar respaldada por una declaración que explique la sustitución de alimentos que se solicita. Debe estar firmado por una autoridad médica reconocida. La declaración médica debe incluir:

- una identificación de la condición médica u otra condición dietética especial que restringe la dieta del niño(a);
- la comida o comidas que se excluyen de la dieta del niño(a); y
- la comida o la elección de los alimentos que se sustituirán.

DK/MP 11/2019

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:_____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

TRAINED STAFF MEMBERS

Name:_____ Room:_____

Name:_____ Room:_____

Name:_____ Room:_____

LOCATION OF MEDICATION

☐ Student to carry

☐ Health Office/Designated Area for Medication

☐ Other: _____

ADDITIONAL RESOURCES

American Academy of Allergy, Asthma and Immunology (AAAAI)
414-272-6071
http://www.aaaai.org
http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf
http://www.aaaai.org/members/allied_health/tool_kit/ppt/

Children's Memorial Hospital
773-KIDS-DOC
http://www.childrensmemorial.org

Food Allergy Initiative (FAI)
212-207-1974
http://www.faiusa.org

Food Allergy and Anaphylaxis Network (FAAN)
800-929-4040
http://www.foodallergy.org

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.

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 _____ *Name* at _____ *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*

6. _____ *Date* _____ *Signature of Parent/Guardian*

FOR SCHOOL 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*

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Allergy History Form

(Return to Nurse/Designated School Personnel)

Dear Parent/Guardian of: Date:

According to your child's health records, he/she has an allergy to:

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

1) When and how did you first become aware of the allergy?

2) When was the last time your child had a reaction?

3) Please describe the signs and symptoms of the reaction.

4) What medical treatment was provided and by whom?

5) If medication is required while your child is at school, the enclosed Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian.

6) Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

Parent or Guardian Print Name: _____

Parent or Guardian Signature: _____ Date: _____

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Forma de Historial de Alergias

(Devuélvalo a la Enfermera/Personal Escolar Designado)

Estimado Padre/Tutor de: Fecha:

Según los registros de salud de su hijo(a), él/ella tiene alergias a:

Por favor proporcione más información sobre las necesidades de salud de su hijo(a) respondiendo a las siguientes preguntas y devuelva este formulario a la oficina de la escuela.

1) ¿Cuándo y cómo se dio cuenta usted por primera vez de la alergia?

2) ¿Cuándo fue la última vez que su hijo(a) tuvo una reacción?

3) Describa los signos y síntomas de la reacción.

4) ¿Qué tratamiento médico se proporcionó y por quién?

5) Si se requieren medicamentos mientras su hijo(a) está en la escuela, el formulario del Plan de Acción de Emergencia (EAP) que esta adjunto debe ser completado por un proveedor médico con licencia y el padre/tutor.

6) Describa los pasos que desea usted que tomemos si su hijo(a) está expuesto a este alérgeno mientras está en la escuela.

Nombre del Padre o Tutor: _____

Firma del Padre o Tutor: _____ Fecha: _____

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

MEDICATION AUTHORIZATION FORM

STUDENT NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE NUMBER _____

SCHOOL _____ GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Steger School District 194, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 194, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Steger School District 194, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Steger School District 194, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization or self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____

II. TO BE COMPLETED BY THE STUDENT'S LISCENSED PRESCRIBER

(Except for a Student Self-Administering Asthma Medication, see Section III Below)

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

TURN PAGE OVER & COMPLETE 2ND PAGE

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Self-Administration of Epinephrine: _____Yes _____ No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____ Yes _____ No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____
Phone Number of Physician Signature of Physician Date

_____ _____
Address of Physician Print Name of Physician Date

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____ No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

FORMA DE AUTORIZACIÓN PARA MEDICAMENTOS

NOMBRE DE ESTUDIANTE _____ FECHA DNACIMIENTO_____

DIRECCION _____ NUMERO DE TELEFON_____

ESCUELA _____ GRAD_____

NOMBRE Y NUMERO DE TELÉFONO DE CONTACTO EN CASO DE EMERGENCIA:
_____

I. DEBE SER COMPLETADO POR EL PADRE/GUARDIÁN DEL ESTUDIANTE

Yo, _____, Padre/Guardián de_____
soy responsable de administrar medicamentos a mi hijo. Sin embargo, en una emergencia médica o si es necesario para la críticas de salud y el bienestar de mi hijo, por la presente autorizo El Distrito Escolar de Steger 194, y sus empleados y agentes, en mi nombre y en mi lugar, para administrar a mi hijo o permitir que mi hijo a administrarse bajo la supervisión de los empleados y agentes de Distrito de 194,legalmente le recetó medicamento de la manera referida en esta forma. Reconozco que puede ser necesario para la administración de la medicación de mi hijo y el tratamiento de la condición de mi hijo a realizar por una persona que no sea la enfermera de la escuela y específicamente el consentimiento de estas prácticas. Notificaré a la escuela por escrito si la medicación si se impide y obtendrá una orden escrita del médico si se cambia la dosis de medicación o tratamiento. Entiendo que esta autorización de medicación sólo es efectiva para el año escolar de _____ y tendrá que ser renovado cada año escolar posterior.

Reconozco y acepto que, cuando así se administra la medicación prescrita legalmente, renuncio a cualquier reclamación que pudiera tener en contra de Distrito Escolar de Steger 194, sus empleados y agentes, provenientes de la administración o auto administración de dicho medicamento, independientemente de si la autorización para la autoadministración de la medicación fue dado por mí, como padres del niño, o por el médico de mi hijo, asistente médico, o enfermera de práctica avanzada. Además, estoy de acuerdo en indemnizar y mantener inofensivo Distrito Escolar de Steger 194, sus empleados y agentes, ya sea conjuntamente o separadamente, de y contra cualquier y todo reclamo, daños, causas de acción o de lastimes, incluyendo honorarios de abogados razonables y costos en defensa, incurridos o resultantes de la administración o auto administración de dicho medicamento, excepto una reclamación basan en una conducta intencional o cierto , independientemente de si la autorización o la autoadministración de la medicación fue dado por mí, como padres del niño, o por el medico de mi hijo, asistente médico o enfermera de práctica avanzada.

Imprime Nombre de Padre/Guardián _____ Fecha _____

Firma de Padre/Guardián _____ Fecha _____

II. DEBE SER COMPLETO POR EL PRESCRIBIDOR/MEDICO CON LICENCIA

(Menos un estudiante que se trata Auto - Administración medicamentos para el asma, Consulte la Sección III)

Diagnóstico: _____ Nombre del Medicamento: _____
Dosificación: _____ Acceso de Administración:_____
Hora/Circunstancias cuando se Debe Administrar Medicación:_____
Efectos Secundarios:_____ Fecha
de la Prescripción: _____ Fecha de la Discontinuación: _____

Voltee a la Página y Completa Página 2

DK/MP 11/2019

Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Auto-Administración de Epinefrina: ___Si ___ No. Los estudiantes mencionados tienen una alergia vida mortal que médicamente requiere la administración inmediata de epinefrina seguida por atención médica de emergencia. He determinado que es médicamente necesario para este niño llevar un auto inyector de epinefrina. El estudiante ha sido instruido en la autoadministración de los medicamentos mencionados y es capaz de administrar la medicación independientemente. El estudiante entiende la necesidad de la medicación y la necesidad de notificar a un miembro del personal y la oficina de salud inmediatamente después de la autoadministración del auto inyector de epinefrina.

Auto-Administración de Medicación para la Diabetes: ___ Sí ___ No. Los estudiantes mencionados han sido diagnosticados con diabetes. He determinado que es médicamente es necesario para que este niño tenga su medicación para la diabetes y el equipo y suministros necesario para monitorear y tratar su condición diabética en virtud de su Plan de Cuidado de Diabetes. El estudiante ha sido instruido en la autoadministración de los medicamentos mencionados y el uso de sus equipos y suministros de diabetes y es capaz de hacerlo independientemente. El estudiante entiende la necesidad de la medicación y la necesidad de informar al personal de la escuela cualquier efecto secundario anormal.

Puedo ser contacto en el siguiente número de teléfono en caso de una reacción a la medicación o una emergencia.

_____ _____ _____
Número de Teléfono del Médico Firma del Médico Fecha

_____ _____ _____
Dirección del Médico Imprimir Nombre del Médico Fecha

III. PARA ESTUDIANTES CON AUTO-ADMINISTRACION DE MEDICAMENTOS DE ASMA SOLAMENTE DEBE SER COMPLETADO POR EL PADRE/GUARDIAN DEL ESTUDIANTE

Diagnóstico: _____ Nombre del Medicamento: _____

Dosificación: _____ Acceso de Administración: _____

Hora/Circunstancia cuando se Debe Administrar Medicación: _____

Efectos Secundarios: _____

Fecha de la Prescripción: _____ Fecha de la Discontinuación: _____

Auto-Administración de Medicamentos para el Asma: ___Si ___ No. Mi hijo ha sido diagnosticado con asma y se le ha recetado medicamentos para el asma por un Calificado Profesional de Salud. Autorizo que mi hijo lleva sus medicamentos para el asma y a administrarse su medicación como lo prescrito por su médico. Nuestro Médico de mi hijo ha dado instrucciones a mi hijo en el auto-administración de su medicación y ha indicado que mi hijo es capaz de hacerlo independientemente. Mi hijo entiende la necesidad de la medicación y la necesidad de informar al personal de la escuela cualquier efecto secundario anormal. He proporcionado la escuela un suministro adicional de su medicamento con una pompa de la prescripción para su uso en caso de que él o ella se olvidan de traer sus medicamentos para el asma a la escuela en un día en particular.

Imprima Nombre de Padre/Guardián _____ Fecha _____

Firma de Padre/Guardián _____ Fecha _____