# Allergy Information Sheet and Checklist

We ask that parents/guardians submit a completed Food Allergy Action Plan and any other required forms at least 7 days before the participant's first day of program. This allows staff time to make accommodations and train appropriate personnel.

**Parent/Guardian Checklist:**
Before the participant's first day of attendance, the parent/guardian/designee is responsible for training selected members of the Park District staff, including but not limited to, the Program Manager, and the program staff on the following:

- ☐ Provide the Program Manager with written medical documentation, instructions, and medications as directed by a physician, using the FARE Food Allergy & Anaphylaxis Emergency Care Plan.
- ☐ Complete Epi-pen/Inhaler waiver.
- ☐ If participant has an Epi-pen, parent should provide the Park District with a separate Epi-pen for each Park District Program the participant is enrolled in, including manufacturer instructions and training by the parent on the use of an Epi-pen.
- ☐ Provide properly labeled medications and replace medications after use or upon expiration.
- ☐ Prescription medications are reviewed and updated regularly by a physician.

**All Park District staff that may have contact with the participant will be trained to know:**

- Events/substances that may trigger allergic reaction
- Limitations on the participant's food consumption
- Symptoms of an allergic reaction
- When and how to administer treatment for an allergic reaction

**Parent/Guardian's Signature**: _____ **Date**: _____

# Dispensing Medication Authorization

**This form must be completed for each program session, for each medication, and/or when medication changes.**

**Program Name:** _____ **Date Completed:** _____

## PARTICIPANT INFORMATION

**Participant's Name:** _____ **Age:**_____

**Address:** _____ **City/State/Zip:**_____

**Parent/Guardian Name:**_____ **Cell Phone:**_____

## MEDICATION INFORMATION

**Medication Name:**_____ **Prescription #:**_____

**Dosage Instructions:** _____

**Frequency Medication Must Be Administered**:_____

**Time Medication Must Be Administered:** _____

**Possible Side Effects:** _____

**Dispensing and Storage Instructions:**_____

**Does the child have any limitations which will occur due to the listed medication?** ☐ **Yes** ☐ **No**

_____

**Other Information:** _____

I understand that it is my responsibility to give the medication directly to program manager with full instruction in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

I authorize Glencoe Park District to administer specific mediation listed above.

In all cases, medication dispensing can only be changed or modified by competing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

**Parent/Guardian Signature:** _____**Date:** _____

GLENCOE PARK DISTRICT

# Waiver and Release of All Claims for Use of Inhaler or Auto-Injector

## Waiver and Release of all Claims and Indemnification

Please read this form carefully and be aware that pursuant to the Illinois Asthma Inhalers at Recreational Camps Act, 410 ILCS 607/1 et seq., you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain in connection with the possession, self-administration, or use of medication, including, but not limited to the use of an epinephrine auto injector or inhaler at the program or at any program-sponsored activity, event, or program; except for claims arising out of the willful and wanton conduct of the Glencoe Park District.

As parent/guardian of the below identified participant, I verify and attest that my child/ward has the knowledge and skills to safely possess, self-administer, and use an epinephrine auto-injector or inhaler in a program setting. I also recognize and acknowledge that there are certain risks of physical injury to participants' possession, self-administration, or use of medication, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said possession, self-administration, or use of medication. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of or arising out of the possession, self-administration, or use of medication against the Glencoe Park District, including its officials, agents, volunteers and employees; except for claims arising out of the willful and wanton conduct of the Glencoe Park District.

I further agree to protect, indemnify, save, defend and hold harmless the Glencoe Park District from and against any and all liabilities, obligations, claims, damages, penalties, causes of action, costs and expenses (including reasonable attorney fees) for which the Glencoe Park District may become obligated by reason of the possession, self-administration, or use of medication; except to the extent caused by the willful and wanton conduct of the Glencoe Park District.

**I have read and fully understand the above waiver and release of all claims and indemnification. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.**

**Participant's Name (please print):** _____

**Parent /Guardian's Signature:** _____ **Date:** _____

## Authorization to Post Allergy Information

I hereby give authorization to the Glencoe Park District to post information in my child's classroom(s) pertaining to my child's allergy, including a photo, the nature of the allergy, and the emergency medical plan.

**Parent /Guardian's Signature:** _____ **Date:** _____

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

History of anaphylaxis: ☐ **Yes** ☐ **No**

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

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. **ADMINISTER 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.

## ADDITIONAL PHYSICIAN COMMENTS

## 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 AND **CALL 911.**

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 and call 911.

☐ **If this box is checked by the child's physician, the child has an extremely severe allergy to _____ and should be given epinephrine at the first sign of any symptoms, even if mild.**

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM ☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

☐ Patient may self-carry ☐ Patient may self-administer

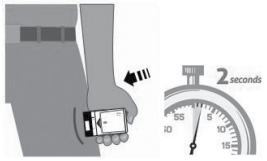
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 8/2025

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

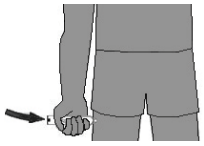
FARE
Food Allergy Research & Education

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



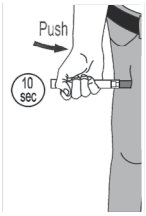

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS



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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

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




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

## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

## 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.

## HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.

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: _____

NAME/RELATIONSHIP: _____ PHONE: _____