FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following foods: _____

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
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 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): _____

_____

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

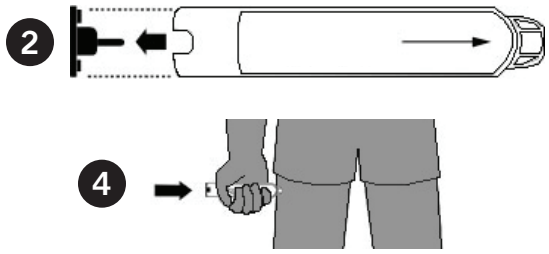
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

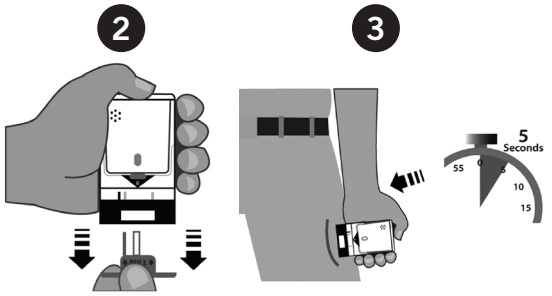
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

4041 Johnston Oehler Rd
Charlotte, NC 28269
Phone 704-717-7550

REQUEST FOR MEDICATION ADMINISTRATION

(each medication must be listed on a separate form)

Valid for school Year 20____ to 20____

Student Name:_____ **Date of Birth:**_____ **Current School Grade:**_____

Medication:_____ **Dosage:**_____ **Route:**_____

Time(s) medication is to be given: A.M. _____ **P.M.** _____ **PRN:** _____

Side effects, Interactions, Etc: _____

Prescribing Health Care Provider Signature:	**Date:**
Health Care Provider Name:	**Phone #:**

Parent/Guardian Agreement: I give my permission for my child (named above) to receive medication during school hours. I agree to send the medication in its original container. As the parent/guardian of this child, I assume the responsibility of any adverse reactions this medicine may cause for my child and I, hereby, release the Board of Directors, School Administration and employees from all liability. I understand that school staff will distribute medication based on the instructions on the original container. This will not be done by a nurse or under the supervision of a nurse.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	**Phone #:**

SELF-MEDICATION STUDENT AGREEMENT *(only applicable for 6th grade and above)*

- Non emergent medications are kept in the office.
- Emergent Medications that can be carried by student *(only if this form is completed and on file)*:
  - **Asthma/Allergic Reactions: ____MDI (Metered Dose inhaler) ____MDI with spacer**
  - **Diabetes: _____Insulin ____ Glucose**
  - **Anaphylaxis: ____Epinephrine**

Health Care Provider Agreement: I agree that this student is authorized to medicate himself/herself, has been instructed and has demonstrated the skill level necessary to use the prescribed medication/device. In order to keep this child in optimum health and to aid school performance it is necessary that this medication be self-administered during school hours. The student's parent/guardian has been informed and is in full agreement.

Healthcare Provider Signature:
(Signature also required at top of form)

Parent/Guardian Agreement: I agree that my child (named above) is knowledgeable of his/her treatment and is capable of self-administering this medication. I understand that the school and its employees are not liable for an injury arising from a student's possession and self-administration of medication. If applicable, I understand that I should provide the school with backup medication that shall be kept in the office so my child has immediate access to their medication in the event my child forgets or loses their supply. I understand that all non-emergent medications will be kept in the office and it is my child's responsibility to go to the office when the medications are due or needed.

Parent/Guardian Signature:
(Signature also required at top of form)

Self-Medicating Student Agreement: I agree and understand how to take my medicine as prescribed by my doctor. I will not share my medicine with anyone. I will keep my emergency medicine in a safe and secure place away from other students. My non emergent medications will be kept in the office and I will go to the office to take them at the scheduled time or as needed. I understand that if I do not follow the above rules, I may lose my privilege to give myself my own medicine while at school.

Student Signature:	**Date:**

To comply with requirements stated in G.S. 115C –375.2, the following must be developed/signed by the student's health care provider and accompany this form: • ***Emergency Action Plan*** *(for students needing an Epi-Pen, Asthma, or Seizure medication;)* • ***Diabetes Care Plan*** *(for students with diabetes).*

******Turn all forms into the front office.******

Nurse Signature_____ **Print** _____