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 STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

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

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 asthmatic): _____

_____

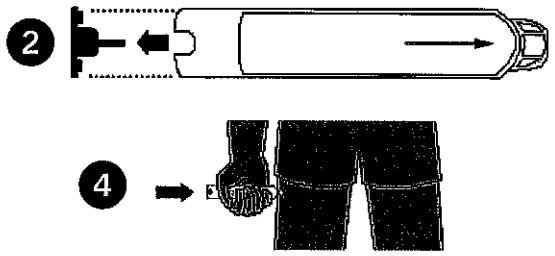
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

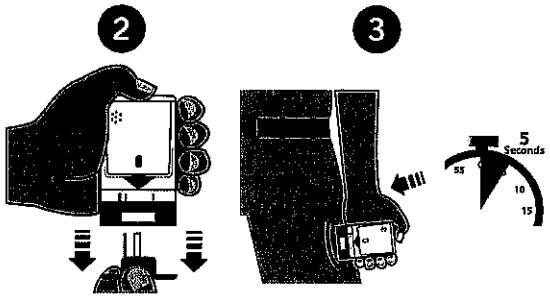
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



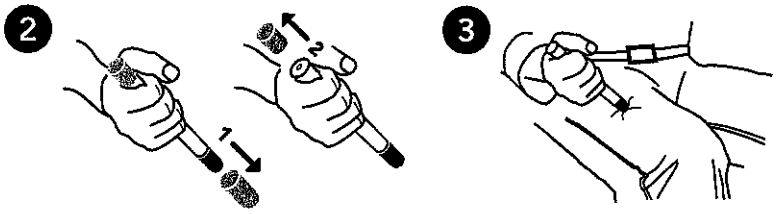
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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 student 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

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CONSENT FOR ADMINISTRATION OF EPINEPHRINE

VIA AUTO-INJECTOR BY A DELEGATE

Student's Name _____ DOB _____

If the procedures specified in N.J.S.S. 18a:40-12.5 AND 12.6 are followed, and the procedures in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" are followed, **St. Joseph Grade School** shall have no liability as a result of any injury arising from the administration of an epinephrine auto-injector to the student.

The parent/guardian shall indemnify and hold harmless the district or school and its employees against any claims arising out of the administration of the administration of the epinephrine auto-injector or the student.

It is the parent/guardian's responsibility to provide a current epinephrine auto-injector. Permission and physician's order are effective only for the school year for which they are granted and must be renewed each subsequent year.

Reviewed with parent/guardian by _____ on _____
Nurses Signature Date

Parent/Guardian Statement:

1. In the event of a potentially life-threatening allergic reaction, as described in the attached physician's order, I authorize the emergency administration of epinephrine via auto-injector to my child _____ by the school nurse or by the delegate _____, who is property trained according to the Protocol and Implementation Plan.

2. I understand that the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration by a Delegate Trained by the School Nurse" are followed by **St. Joseph Grade School**, as well as its employees or agents, shall have not liability as a result of any injury arising from the administration of the epinephrine auto-injector to my child.

3. I indemnify and hold harmless _____(school nurse) as well as it's employees and agents, against any claims arising out of the administration of an epinephrine auto-injector to my child.

4. I will provide a current epinephrine auto-injector o the school, and will replace it with a new one at least 2 weeks before it expires.

5. I understand my permission is granted only for this current school year.

Parent/Guardian Signature _____ Date _____
Relation to Student _____

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Student: _____ _____
Last First DOB

St. Joseph Grade School Grade _____ Teacher: _____ Room: _____

PARENTAL REQUEST:

I, the parent/guardian of _____, authorize the Principal and School Nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability as a result of any injury arising from the self-administration of medication by the students and I hold harmless the school, school nurse and principal against any claims arising out of the self-administration of medication by the student.

I agree to bring a weekly supply of the mediation to the school nurse. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

Parent/Guardian Signature: _____ Date _____

Address: _____ Phone_____

****

PHYSICIAN'S STATEMENT

In order to protect the health of _____ it is necessary for him/her to have the following medication during school hours.

Name of Medicine: _____

Dosage: _____

Purpose of medication _____

List significant side effects: _____

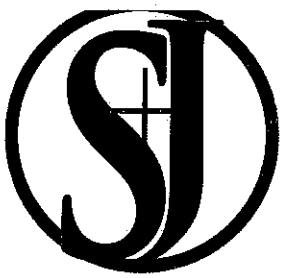
DIAGNOSIS: _____

I request that the student be allowed to carry and self-administer the prescribed medication. I certify that the student is capable of and has been instructed in the proper methods of self-administration.

Date: _____ Physician's Signature: _____

Print Physician Name: _____

Physician Address & Phone #: _____



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AUTHORIZATION FOR RELEASE OF INFORMATION ON NEED-TO-KNOW-BASIS

___[District]_____ Public Schools strive to protect the well-being of our students, especially those with special health needs. This includes assisting teachers, students and administrators to adapt to a student's health problems.

Because of this commitment it is important that certain confidential information about the student's health problem be shared by parents or guardians. This information will be used to plan for the care and management of the student. It will be shared with those members of the professional staff who have direct responsibility for the student when in school or participating in school activities.

Please complete the release below:

I hereby authorize an exchange of information to occur between the School Nurse, my child's physician and those members of the professional staff that have direct responsibility for my child when in school or when participating in school activities.

Student's name: _____

Date of birth: _____

Address: _____

Phone: _____

This authorization is effective for one calendar year.

_____ _____
Parent/Guardian Signature Date

_____ _____
School Principal's Signature Parent/Guardian Signature

_____ _____
School Nurse's Signature Date