Form A.2 Food Allergy & Anaphylaxis Emergency Care Plan

(Physician and parent/guardian signatures required annually)

SEVERE ALLERGY

PLACE PICTURE HERE

Name: _____ Form: 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 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

See next page for more instructions and physician/parent signatures

Authorization for Posession and Use of an Epinephrine Autoinjector

(Physician and parent/guardian signatures required annually)

Columbus School for Girls

Student Name:_____ Form:_____

This section should be completed and signed by the student's parent/guardian.

☐ *As the Parent/Guardian, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. My child understands that they must notify a school employee in the event that they administer this medication. I will provide a backup dose of the medication to my child's Division Director or nurse as required by law.*

- OR -

☐ *I do not want my child to carry or administer their own epinephrine.*

☐ *I will send 2 epi-pens or other epinephrine devices to the school nurse at the beginning of the school year.*

Signature of Parent/Guardian:_____ Date:_____

Parent/Guardian Name:_____ Emergency Phone:_____

This section should be completed and signed by the student's physician.

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Signature of Physician:_____ Date:_____

Physician Name:_____ Phone:_____