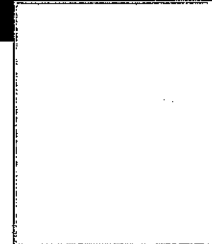
FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN



Name: ______________________ D.O.B.: __________

Allergy to: ______________________

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

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

Extremely reactive to the following allergens: ______________________

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

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. **INJECT 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. Patient should remain in ER for at least 4 hours because symptoms may return.

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.

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 or Generic: ______________

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ______________

Antihistamine Dose: ______________

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

____

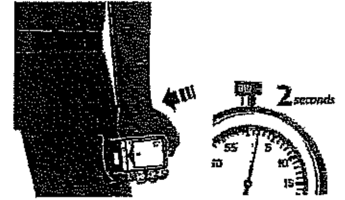
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE
Food Allergy Research & Education

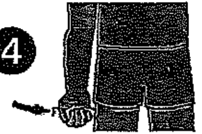
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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



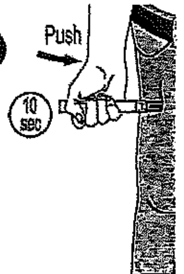
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

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



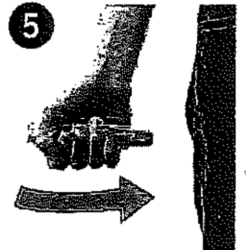
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

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



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. 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.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. 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.

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 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: ____________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

WARDLAW+HARTRIDGE SCHOOL 20__-20__
ALLERGY ACTION PLAN & ALLERGY MEDICATION ORDERS
Note 4-page document-doctor must sign/ stamp** both pages 1& 3***

Student Name: ______________________ DOB ________________ **History:**
Circle those that apply:

This student has a ***known*** life-threatening allergy to: (list **triggers/allergens)**

____

This student has a *potential* life-threatening allergy to: (list **triggers/allergens)**

____

Previous **anaphylaxis**? NO ***OR*** YES, **list** date ________________________
List Symptoms____

Previous **allergic** reaction? NO or YES, **list date**______________________
List Symptoms ____

Is this student **asthmatic**? NO **or YES** (asthmatic students have higher risk of reaction)

Other important medical info-None **or** List

____

Other medications school should know about? None **or** List

____

Physician's Signature ______________________________**date**_____

Physician's Stamp

****
School Nurse use only in this section.
EpiPen delegates trained: (name & extension to be reached)
Name____
Name____
(Note separate document maintained for training protocol documentation)

Parent Sheet***Parent must read entire 4-page document & sign pages 1, 2 & 4**
(Students 18+must sign own form)

Epinephrine Authorization Form, Policy & Release School Year 20 - 20

I hereby agree to indemnify and hold harmless Wardlaw+Hartidge School, its employees, agents, nurse, nurse's employers(s)/ESCNJ, and any epinephrine designees/delegates, from any claims arising from the administration of a pre-filled auto-injector mechanism containing epinephrine. I understand this release covers any acts or omissions done in good faith, but shall not include willful misconduct, gross recklessness or negligence. I am aware nurse trains and approves volunteer delegates based on state codes. A delegate can give an epinephrine pre-filled auto-injector if nurse unavailable.
I am aware I must notify school nurse in advance if my child needs an epinephrine pen delegate for field trips, events, sports, encore etc.
I am aware and agree to provide the school with **two (2) un-expired** EpiPens/Auvi Q/Epinephrine pre- filled auto injectors at all times. Parent is responsible for supplying all medications, ordered by the Doctor, to the school nurse. All medications sent in must be **new, unopened, unexpired**, and in their original box, with the pharmacy label as appropriate. I will periodically contact school nurse to check about medications expiration dates.
I am aware and agree this document and medical information can be shared on a need to know basis with school personnel or emergency personnel as deemed necessary by school nurse or school authorities.

Student name____

Parent or Guardian name (print) ____________________________

Parent or Guardian Signature______________________________

Date____

THE WARDLAW+HARTRIDGE SCHOOL AUTHORIZATION FOR MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT**: School Year: 20__ - 20__

Child's Name:______________________________ *Date of birth:*_______________ *grade:*_________

I request that my child be assisted in taking the medicine described below at school by authorized persons. The medication prescribed below is needed during school hours for my child to properly function and cannot be given at home. Herbal and dietary supplements are not considered medications and cannot be given in school. All medication must be **brought to school by a parent/guardian**, **in an original unopened labeled pharmacy container**, including for over-the-counter medications also. Please check and note expiration date. At the conclusion of treatment/school year (whichever is first) parent/guardian **must pick up** medication or it will be **discarded** on the last day of school. Changes to regime must be put in writing by prescribing physician. I agree that information may be shared with appropriate school personnel on a need to know basis. Neither the Wardlaw+Hartridge School employees or school nurse, and/or the Educational Services Commission of NJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the authorized administration of medication.

___________ ______________________________ ____________________________________

Date PRINT NAME parent/guardian Parent/Guardian Signature

Student s 18 and over must sign form themselves

The following section is to be completed by the **PHYSICIAN**:

Child's name:_________________________ DOB:__________________ Diagnosis:_______________

Medication: __________________________Dosage: __________________ Route: _______________

If medicine is to be given daily, at what time? ____

If medicine is to be given "when needed," describe indications: __________________________________

How soon can it be repeated? ____

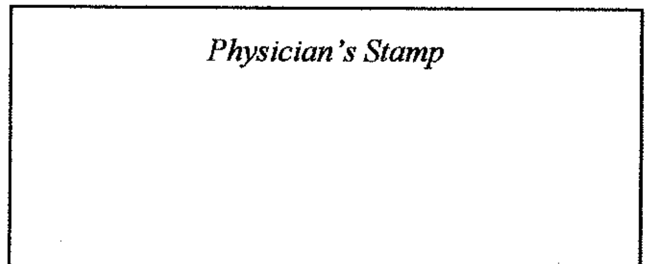
Length of time this treatment is recommended: ____

Print Physician's Name: ______________________

Signature of physician: _______________________

Address/telephone number______________________

Date: ____________________________________



Physician's Stamp

THE WARDLAW+HARTRIDGE SCHOOL School Year 20____ - 20____

PARENT/GUARDIAN PERMISSION FOR MINOR STUDENT TO SELF-ADMINISTER MEDICATION

I, the parent/guardian of ____ authorize my child, a pupil at The Wardlaw+Hartridge School to self-administer medication prescribed by our physician as described below for a life-threatening condition. Such Medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and Diabetic Care/Medications. I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither The Wardlaw+Hartridge School employees or nurse, and/or ESCNJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the selfadministration of this medication by my child, or misuse of the medication. I agree that this information will be shared on a need to know basis with school personnel. All medications must be non-expired and be brought to school in an original, unopened labeled pharmacy container, including for over-the-counter medications.

Parent/Guardian Signature ___________________print name___________________Date_____________

(*See other side****) 2-sided document 18 and over must sign this form**

PHYSICIAN'S AUTHORIZATION/ASSURANCE STATEMENT FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION I certify that ________________________is under my care for a life-threatening condition. I am recommending that the above-named student be permitted to self-administer medication. He/She is capable of, and has been instructed by me in the proper method of self-administration of the following medications: (Such medication is generally limited to Asthma Inhaler, pre-filled Epinephrine autoinjector with or without a unit dose of Benadryl, and IDDM meds)

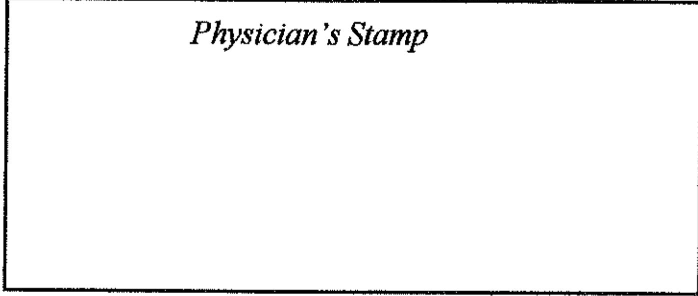
Name and Purpose of Medication: ____

Identification of life-threatening medical problems: ___________________________________

Prescribed dosage/route/schedule: ____

Length of time medication to be taken: ____

Possible side effects and/or special precautions: ______________________________________



____

Prescribing Physician's Signature

____

Please print name and address of Prescribing Physician

____

Telephone # date

NEITHER THE WARDLAW+HARTRIDGE SCHOOL NOR ANY EMPLOYEE OR NURSE, NURSE'S AGENTS/EMPLOYER, ESCNJ NURSE(S) SHALL BE RESPONSIBLE FOR ANY LIABILITY AS A RESULT OF ANY INJURY TO THE ABOVE-NAMED STUDENT, ARISING FROM THE SELFADMINISTRATION OF MEDICATION OR ANY MISUSE OF THE MEDICATION.

Parent Form (see other side; 2-sided document**)**

Self-Administration Policy & Release

Students who self-administer must be authorized to do so **in writing** by their doctor and parent, and as approved by school nurse. See school nurse for forms. "Self-Administrators" are responsible to carry and self-administer their approved medications **with them at all times.** This includes before, during, and after school, as well as **any and all** school functions, performances, trips, clubs, activities, or sports events. The medication(s) the student's doctor orders must be sent with the student daily **from home.** As a parent, you agree to oversee that your student has the **appropriate, un-expired, properly pharmacy labeled** medications with them daily. Parent agrees to share this policy, review this policy with your child. Student and parent agree not to share his/her medications with anyone. Furthermore, all agree the student will tell the person in charge of the school event they have taken medication. The school nurse should also be informed when available. Student must seek adult help immediately at any time he/she needs to, or if there is a problem or concern, as well as seek out school nurse with questions.

We agree to indemnify and hold harmless the Wardlaw+Hartridge School, its employees/agents; and school nurse/nurse's employer(s), ESCNJ's employees/nurse(s) from any claims arising from failure of parent or student following this policy/procedure.

I understand and have instructed my child, along with his or her doctor's guidance, in proper use, storage, and administration of the prescribed medication(s). I will only send in the prescribed amount needed.

Self-administrators are also required to keep a "back-up" set of medications in the nurse's office for emergency use (while still carrying a set of their "own" medications with them daily).

Student Name ______________________________

Parent/Guardian print name______________________

Parent/Guardian signature______________________