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 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
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 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/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 or Generic: _____

Epinephrine Dose: ☐ 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

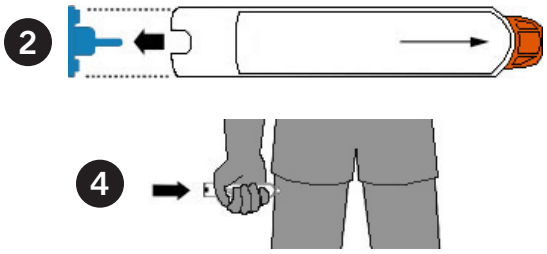
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR 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 enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

PHYSICIAN INSTRUCTIONS

For **SCHOOL ASSISTED MEDICATION**

School _____

School Phone # _____

School Fax # _____

This form must be completed before any medication (prescription or over-the- counter) can be given, or taken, at school. Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medications.

Student Name: _____ Date of Birth: _____

PHYSICIAN USE ONLY

Medication: _____ Dose: _____ Reason/Diagnosis: _____

Start Date: _____ Stop Date: _____

Route: ☐Oral ☐Nasal ☐Topical ☐Inhale ☐Injection ☐Other _____

Frequency: _____

Other Instructions: _____

Medication: _____ Dose: _____ Reason/Diagnosis: _____

Start Date: _____ Stop Date: _____

Route: ☐Oral ☐Nasal ☐Topical ☐Inhale ☐Injection ☐Other _____

Frequency: _____

Other Instructions: _____

Physician's Signature: _____ Date: _____

Physician's Name: _____

Address:_____ City: _____ Zip Code:_____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year

California Education Code section 49423 provides that any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.

California Education Code section 49423 (c) A pupil may be subject to disciplinary action pursuant to Sections 48900 if that pupil uses an inhaler or auto-injectable in a manner other than as prescribed

Parent Request

For Assistance with Medication at School

This form must be completed before any medication (prescription or over-the- counter) can be given, or taken, at school. Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in medications.

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. I hereby request that the staff of my child's school assist in giving medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Signature of Parent/Guardian: _____ Date:_____ Phone Number: _____

B. For ASTHMA INHALER/EPINEPHERINE AUTO-INJECTORS self-administrated only: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. I also give permission to contact the physician for consultation and exchange of information as needed.

Signature of Parent/Guardian: _____ Date:_____ Phone Number: _____

Student Contract – Asthma Inhalers Only

I agree to keep my medication in a safe and secure place, such as on my person, at all times. I agree I will NEVER share my medication with another student. If I am using my inhaler more than once a day, I will speak with the school nurse.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

All medication orders will be automatically discontinued at the end of the school year. New orders are required each school year

California Education Code 49423 (c) A pupil may be subject to discipline action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Victor Valley Union High School District

16350 Mojave Dr. Victorville, CA 92395
760.955.3201 ex. 10238

CHRONIC ILLNESS VERIFICATION FORM (CIVF) INFORMATION

The Chronic Illness Form allows parents to excuse absences due to a specific medical condition with the same authority as a medical professional. Below are guidelines for completing the form correctly to establish and maintain this authorization.

1) **Victor Valley Union High School District** does not accept any CIVF that does not have the expected frequency of episodes, length of absence, diagnosis, appropriate symptoms listed, Physician's or Medical Group letterhead/business card attached and appropriate signature(s). Please return the form to parent for completion.

2) The school site may fax the CIVF back to the Physician's office to verify the document's authenticity. An administrator or their designee must refuse acceptance of any CIVF found to be fraudulent.

3) Please monitor the expected frequency and length of episode for absences excused for reasonable compliance with the Physician's guidelines outlined on the form. If there is a concern about the child not making academic progress due to these absences or that the privilege is being misused, the school will contact the student and/or parent to discuss these concerns. For some chronically ill children, alternative educational programs may meet their needs more appropriately.

4) If the site has unresolved concerns, after talking with the student and/or parent, designated Health Services staff will contact the authorizing Physician with specific questions related to the diagnosis and absenteeism. We will refer to the CIVF if the parent initials require contact with them prior to accessing the Physician.

5) Remember, the form expires at the end of the academic year. Obtain a new form annually.

STUDENT AND PHYSICIAN VERIFICATION

Student:_____ DOB: _____ Grade: _____

Forward to: _____ _____
School FAX number

Dear Physician,

Your patient is a student enrolled in [enter school district here]. For your records, please list the chronic illness diagnosed for the student. Also, please check or list symptoms that would not warrant an office visit, but might require the child to stay home from school. This will allow the parent to verify illnesses, by listing in writing to the school the symptoms designated below, without bringing the child to your office for an examination. This document expires at the end of the academic year that it is/was received.

_____ _____
Physician signature and printed name here Date

Please Attach Businesss Card

Address_____

Chronic Illness/Medical Diagnosis_____

Symptoms_____

Expected frequency of episodes_____
(for example: monthly, 4 times per school year, etc.)

Length of absences per episode_____

SYMPTOMS

Neurological System

__ lethargy

__dizziness/unsteadiness

__numbness in extremities

__petit mal seizures

__severe headache

__blurred vision

Respiratory system

__weakness/fatigue

__pallor/cyanosis

__continual coughing

__congested airway

__difficulty breathing

__pain

Gastrointestinal system

__nausea/vomiting

__diarrhea

__constipation

__abdominal pain

Integumentary system

__skin lesions

__infections

__edema

Musculoskeletal system

__pain

__inflammation/swelling

Cardiovascular system

__weakness/dizziness

__pallor/cyanosis

__palpitations

__rapid pulse

__arrhythmia

__pain

__fever/infections

Genitourinary system

__bladder/kidney infection

PARENT/GUARDIAN AUTHORIZATION

I hereby request and authorize the exchange of information on the above diagnosis pertaining to my child between Health designated staff of the **Victor Valley Union High School District** and the physician named above.

I request **Victor Valley Union High School District** to inform me, the parent/guardian signing this authorization before contacting the authorizing medical professional. ____ (initial here to request).

This contact will only be made if the frequency or length of absences exceeds the numbers authorized above. **I further understand I must submit written explanations to verify each absence.**

Parent signature: _____ **Date:** _____

Food Allergy History

Student Name: _____ Date of Birth: _____

ID#: _____ School: _____ Grade: _____

Parent/Guardian Name(s): _____

Parent Telephone Home #: _____ Cell #:_____ Work #:_____

Emergency Contact: _____ Relationship to Student: _____

Emergency Contact Number: _____

Health Care Provider: _____ Telephone #: _____

1. Allergy to _____
2. Is your child's food allergy considered life threatening?

   ☐ No ☐ Yes

   If yes, by State Law, your child may not attend school until the health care provider orders for this condition have been provided. Please contact the School Nurse.

3. Does your child have asthma? ☐ No ☐ Yes
4. Does your child have any other health condition(s) or medication allergies? ☐ No ☐ Yes

   Explain:_____

5. Describe your child's symptoms to an allergic reaction: _____

   _____

6. Is your child able to identify foods that may cause a reaction? ☐ No ☐ Yes
7. Is your child able to recognize symptoms of their allergic reaction? ☐ No ☐ Yes
8. Has your child received medical care because of an allergic reaction to food? ☐ No ☐ Yes
9. Are the any limitations, restrictions or other precautions needed at school? ☐ No ☐ Yes

   _____

10. Is a completed Food Allergy Care Plan on file? ☐ No ☐ Yes
11. Is a Medication Plan on file? ☐ No ☐ Yes

_____ _____

Signature of Parent/Guardian Date

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Child or Adult Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment.

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.

9. The participant's disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:

11. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

12. Indicate food texture for above participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive equipment to be used:

15. Signature of Recognized Medical Authority*	16. Printed Name	17. Telephone Number	18. Date

***For this purpose, a recognized medical authority in California is a licensed physician, physician assistant, or nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, etc.).
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability (e.g., Allergy to peanuts causes a life-threatening reaction).
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the recognized medical authority.
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    B. Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
16. **Printed Name:** Print name of medical authority.
17. **Telephone Number:** Telephone number of medical authority.
18. **Date:** Date medical authority signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.