FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN & TREATMENT AUTHORIZATION

Appendix F-4A

PART I - TO BE COMPLETED BY PARENT

Student: _________________________________ D.O.B: __________ Teacher/Grade:_____________

Allergy to: ____ Weight: ________________lbs.

Asthma: ☐ **Yes (Higher risk for severe reaction)** ☐ No

Note: Antihistamines and Inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHRINE

PART II - TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

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, wheeze, repetitive cough
HEART	Pale, blue, faint, weak pulse, dizzy, confused
THROAT	Tight, hoarse, trouble breathing or swallowing
MOUTH	Significant swelling (tongue or lips)
SKIN	Many hives over body, widespread redness
SKIN	Hives, itchy rashes, swelling
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 anaphylaxix and may need epinephrine when emergency respnders 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 down on their side.
- Ifsymptoms 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 at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE	Itchy or runny nose, sneezing
MOUTH	Itchy mouth
SKIN	A few hives around mouth/face 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 BELOW DIRECTIONS

1. **GIVE ANTIHISTAMINE** if ordered.
2. Stay with student, alert emergency contact.
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: ___________________________________

(Antihistamines should NOT be used as a first line of treatment during an anaphylaxis episode. It will treat itching ONLY-it will not halt vascular collapse or swelling!)

Other (e.g., Inhaler-bronchodilator if wheezing):____

It is my professional opinion that this student SHOULD/SHOULD NOT carry his/her epinephrine auto-injector.

____________________________/_________________________________ ________________________ _______________

Licensed Health Care Provider Authorization (Print / Signature) Telephone Date

Form adapted compliments of FARE www.foodallergy.org *Revised 2019*

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PART III - PARENT SIGNATURE REQUIRED

Student_________________________________ Date of Birth _____________Teacher/Grade____________

Administration of an oral antihistamine should be considered only if the student's airway is clear and there is minimal risk of choking.

MONITORING

Stay with student, Call 911 and then emergency contact. Tell 911 epinephrine was given, request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given about 5 minutes or more after the last dose.

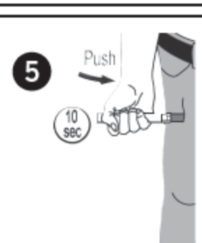
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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.):

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN & TREATMENT AUTHORIZATION

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A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this action plan and treatment authorization. A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS:

Name/Relationship: ____ Phone:___________________________

Name/Relationship: ____ Phone:___________________________

Name/Relationship: ____ Phone:___________________________

I hereby authorize for school personnel to take whatever action in their judgment may be necessary in providing emergency medical treatment consistent with this plan, including the administration of medication to my child. I understand the Virginia School Health Guidelines, Code of Virginia, 8.01-225 protects school staff members from liability arising from actions consistent with this plan.

____ _______________________ ____________________

Parent / Guardian Authorization Signature Telephone Date

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN & TREATMENT AUTHORIZATION

Appendix F-4A

EPINEPHRINE AUTHORIZATION

FOR USE WITH ANTIHISTAMINE AUTHORIZATION AND ALLERGY ACTION PLAN

Release and indemnification agreement

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for administering this injection, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures outlined on the back of this form and assume responsibility as required

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Student Name (Last, First, Middle)		Date of Birth
Allergies:	School: **OUR LADY OF GOOD COUNSEL**	School Year: **2022-2023**

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances

_________________________ Parent or Guardian Signature   _________________________ Daytime Telephone   ______________ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS.

Emergency epinephrine injections may be administered by trained non-health professionals. These persons are prepared by licensed health care personnel to administer the injection. For this reason, only pre-measured doses of epinephrine (auto injector) may be given.

After report of student exposure to _____________________ (specific allergens), via (route of exposure) ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Insect bite or sting the following action will be taken;

☐ The following injectable epinephrine dosage will be given <u>immediately</u>, as prescribed below.

☐ The following injectable epinephrine dosage will be given as noted below and as detailed on the attached Allergy Action Plan (F-4A),in conjunction with the Antihistamine Authorization Form (F-4B)

Check ✓ appropriate boxes:

☐ EpiPen 0.3   ☐ Teva Generic EpiPen 0.3   ☐ Impax 0.3   ☐ Auvi-Q 0.3

☐ Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh.

☐ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

☐ EpiPen Jr. 0.15   ☐ Teva Generic EpiPen 0.15   ☐ Impax 0.15   ☐ Auvi-Q 0.15

☐ Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3 cc) by auto injection, intramuscularly in anterolateral thigh.

☐ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

COMMON SIDE EFFECTS

EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which medications are to be taken

Check ✓ appropriate box:

☐ I believe that this student has received adequate information on how and when to use an epinephrine auto injector, and has demonstrated its proper use.

a. The student is to carry an auto injector during school hours with principal approval. The student can use the auto injector properly in an emergency.

b. One additional dose, to be used as backup, should be kept in clinic or other school location.

☐ The auto injector will be kept in the school clinic or other school approved location __________________.

_________________ Licensed Health Care Provider (Print or Type)   _________________ Licensed Health Care Provider (Signature)   ____________ Telephone or Fax   __________ Date

_________________ Parent or Guardian (Print or Type)   _________________ Parent or Guardian Signature   ____________ Telephone   __________ Date

_________________________ Student Signature (Required if student carries Auto injector)   __________ Date

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN & TREATMENT AUTHORIZATION

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ANTIHISTAMINE AUTHORIZATION

Release and indemnification agreement

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Student Name (Last, First, Middle)		Date of Birth
Allergies	School: **Our Lady of Good Counsel**	School Year: **2022-2023**

No LPN or clinic room aide shall administer medication or treatment, unless the principal has reviewed all the required clearances.

____ Parent or Guardian Signature

____ Daytime Telephone

______________________ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS

The school discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

ALLERGIC REACTION TO: EXPOSURE- INGESTION ☐ CONTACT ☐ INHALATION ☐ STING ☐	SIGNS / SYMPTOMS:
MEDICATION:	ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL:	TIMES OR INTERVAL TO BE GIVEN:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which medications are to be taken

COMMON SIDE EFFECTS:

___________________________________ Licensed Health Care Provider (Print or Type)

_______________________________ Licensed Health Care Provider (Signature)

___________________ Telephone or Fax

____________ Date

___________________________________ Parent or Guardian Name (Print or Type)

_______________________________ Parent or Guardian (Signature)

___________________ Telephone

____________ Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. *It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.*

☐ Auto injector is appropriately labeled. _________________ Date by which any unused Auto injectors are to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

I have reviewed the proper use of an Auto Injector with the student and, ☐ agree ☐ disagree that student should self carry in school.

☐ Antihistamine Medication is appropriately labeled.

☐ Date by which any unused medication is to be collected by the parent: __________(Within one week after expiration of the physician order or on the last day of school).

____ Signature

_______________________________ Date

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the** ***Office of Catholic Schools Policies and Guidelines*** **and** ***Virginia School Health Guidelines*** **manual**.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (e.g. inhaler, autoinjector). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
   a. Student name
   b. Date of Birth
   c. Diagnosis
   d. Signs or symptoms
   e. Name of medication to be given in school
   f. Exact dosage to be taken in school
   g. Route of medication
   h. Time and frequency to give medications, as well as exact time interval for additional dosages.
   i. Sequence in which two or more medications are to be administered
   j. Common side effects
   k. Duration of medication order or effective start and end dates
   l. LHCP's name, signature and telephone number
   m. Date of order

10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, auto injector)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.