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 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

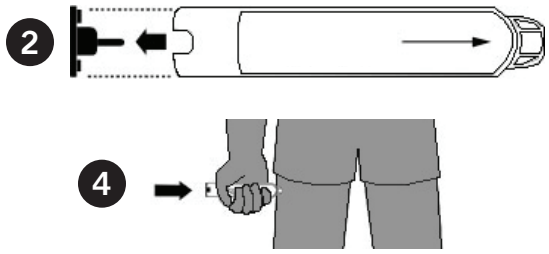
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

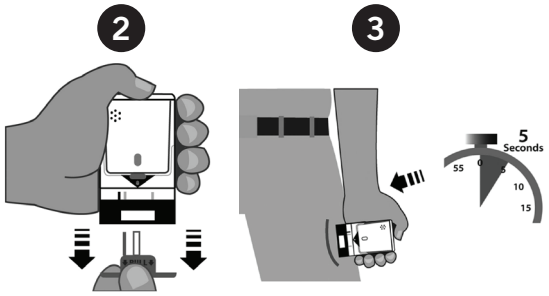
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 someone 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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

DUNELAND
HEALTH SERVICES

SPECIAL DIETARY NEEDS FORM

Duneland School Corporation participates in a federally funded Child Nutrition Program and any meals and/or milk served must meet program requirements. Reasonable meal accommodations are made when the request is due to a disability or impairment. If you are requesting a meal accommodation or substitution, please have this form completed and signed by a Healthcare Practitioner (MD, DO, or NP) as well as a parent/guardian.

If you have any questions, please contact Tammy Watkins, Child Nutrition Director for the Duneland School Corporation at 219-983-3700 x 6162 or by email at Twatkins@duneland.k12.in.us. **Please return completed forms to the school nurse.**

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent's Name: _____ Phone: _____

To be completed by the physician:

FOOD(S) TO OMIT	FOOD(S) TO SUBSTITUTE

Healthcare Practitioner Name (Please Print) _____ Healthcare Practitioner Signature _____ Date _____

Office Telephone Number _____ Office Fax Number _____

Parent/Guardian Name (Please Print) _____ Parent/Guardian Signature _____ Date _____

DUNELAND SCHOOL CORPORATION
HEALTH SERVICES

Student:_____ Grade:_____

Students with food allergies may now sit at our designated "Allergy-Friendly Table". Your child may have 1 or 2 friends sit with him/her at this table if they have a safe lunch. The cafeteria supervisors will help with the procedure to avoid any confusion.

Please indicate below if **you want <u>or</u> do not want** your child to sit at our "Allergy-Friendly Table" during lunch.

_____ Yes, I want my child to sit at the table.

_____ No, I don't want my child to sit at the table.

_____ _____
Parent's Signature Date

Rev. 5/16

DUNELAND
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER PRESCRIPTION & NON-PRESCRIPTION MEDICATION

NAME _____ **SCHOOL** _____ **GRADE** _____

☐ SCHEDULED

MEDICATION _____ **DOSAGE** _____ ☐ AS NEEDED **TIME** _____

REASON FOR GIVING _____ **START DATE** _____ **END DATE** _____

THIS SECTION REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

_____
Physician Signature
(Or copy of current label)

I have prescribed the medication(s) below and authorize the nurse or the principal designee to administer the medication(s) as follows with time adjustments to accommodate lunches, late arrival, early dismissal, etc.

This patient has demonstrated they are capable of following the instructions regarding safe and appropriate use of this emergency medication and should be permitted to carry this medication provided permission has been granted per school guidelines *(Controlled substances not permitted to be carried by student).*

_____
Physician Signature
(Must be signed for student to self-carry)

_____ _____ _____
Healthcare Practitioner Name (Printed) **Phone Number** **Date**

PARENT AGREEMENT/AUTHORIZATION:

- The nurse and/or the principal designee has my permission to administer this medication to my child as prescribed and/or directed
- The parent/guardian is responsible for supplying this medication to the school in an original labeled container (this includes pharmacy labels for prescription medications)
- The parent/guardian is responsible for replacing medications on/before their expiration dates
- Changes to the medication dosage and/or administration frequency require a new Authorization to Administer Medication Form be completed along with physician signature or updated pharmacy label for prescription medications
- Authorization to Administer Medication Form must be renewed each school year
- Student's may not be in possession of or transport medications without a current Authorization to Administer form on file
- Medications not picked up at the end of the school year will be disposed of properly
- Parent/Guardian is responsible for notifying the nurse or principal designee if the medication is not to be given for any reason (late arrival, early dismissal, discontinuation, etc.)

_____ _____ _____
Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

DUNELAND
HEALTH SERVICES

Student Name: _____ Date: _____ Class: _____

Dear Parents/Guardian,

In preparation for the end of the school year, we must coordinate the return of any remaining medication your child has at school. Per Duneland School Corporation policy, medication that is possessed by a school for administration during school hours may be released to the student's parent/guardian or to an individual who is 18 years of age or older and who has been designated, in writing, by the student's parent/guardian to receive the medication. A school may send medication not classified as a controlled substance that is possessed by a school for administration during school hours with a student only if the student's parent/guardian provides written permission for the student to receive the medication. The completion of this form and submission to the school nurse serves as an official written permission.

Medication Returned:	QTY	NAME OF MEDICATION
	_____	_____
	_____	_____
	_____	_____

_____ I will pick up my child's medication by _____ and understand that any medications not picked up on or before Thursday, May 30, 2024 or medications not being forwarded to summer school will be discarded.

_____ Please send my child's medication home no sooner than_____ (Controlled substances cannot be sent home with student)

_____ Please forward my child's medication to _____school for 2024 summer school

_____ I authorize _____ who is at least 18 years of age to pick up my child's medication on or before Thursday, May 30, 2024

_____

Parent/Guardian Name (Printed)

_____ _____

Parent/Guardian Signature Date

Inspire | Engage | Empower

If your child has a food allergy/intolerance that requires diet modifications please send a Food Allergy & Anaphylaxis Emergency Care Plan to the school yearly. Also, please send an email to the school nurse and to Tammy Watkins, Child Nutrition Director for Duneland School Corporation (tammitwatkins@duneland.k12.in.us).

The following page (Consent for release of medical information) only needs to be completed and signed by a parent/guardian if you prefer for the nurse to fax all the necessary forms to the physician to be completed. After signing this and all the required forms, please send them to the school to be faxed to the physician.

DUNELAND SCHOOL CORPORATION
601 W Morgan Avenue; Chesterton, In 46304
219-983-3600 fax 219-983-3614

Student/ Patient Name:_____ Date of Birth:_____

☐ Send from: ☐ Send to:	☐ Send from: ☐ Send to:
Duneland School Corporation **(and its affiliates, employees and agents)** **601 W Morgan Avenue Chesterton, In 46304** **219-983-3600 fax 219-983-3614** Attn: (name and title): _____	Agency: _____ (and its affiliates, employees and agents) Address: _____ City/State: _____ Phone number: _____ Fax number: _____ Attn: (name and title) _____

A. Information to be disclosed:

Typical **School** Information)

☐ Transcripts, report cards, attendance reports
☐ School Health Records
☐ RTI Data/General Education Referral
☐ Specialized/Diagnostic Evaluation
☐ Special Education Records/Psychological Evaluation
☐ Discipline and Behavior Records
☐ Other _____
_____

(Specific Mental Health/Health Agency Information to be released)

☐ Entire medical record including all of below:
☐ Medical History/Hospitalization
☐ Summary of Psychiatric Treatment
☐ Medication History
☐ Psychiatric Evaluation Results
☐ Mental Disorder/Diagnosis
☐ Most Recent Contact Date
☐ Drug and Alcohol Information
☐ Treatment Plan
☐ Clinician's Office Notes
☐ Patient Histories
☐ Test Results
☐ Records sent to you by other health care providers

By signing here, _____, I give specific authorization to disclose the following:

☐ HIV test results ☐ Drug and alcohol abuse treatment records ☐ Psychotherapy notes
☐ Documentation of AIDS diagnosis ☐ Psychiatric/Mental health treatment records

B. Purpose of Disclosure:

☐ At the request of the individual or ☐ Other:_____
_____

C. Authorization to Discuss Health Information

☐ By initialing here _____ (Initial) I authorize _____ (Name of individual health care provider) to discuss my health information with the School listed here:

_____
(Name of individual or school entity)

D. Authorization Statements:

- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the Superintendent of Duneland School Corporation, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

_____ _____
Signature of Adult Consenting to Release (Either Employee or Parent) Date

_____ _____
Student Signature (if aged 12 or older) Date