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

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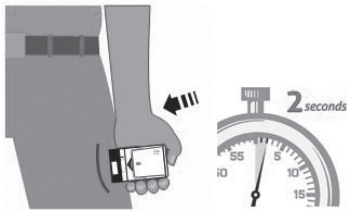
FARE
Food Allergy Research & Education

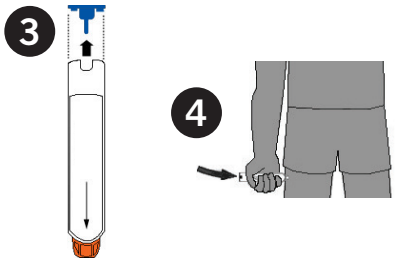
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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.



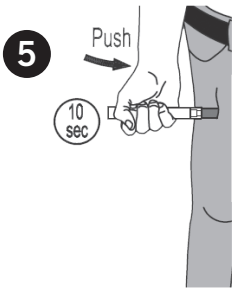
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

STUDENT ALLERGY CARE PLAN

Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare Provider? ☐ No ☐ Yes

2. History and Current Status

a. What is your child allergic to?

☐ Peanuts
☐ Eggs
☐ Milk
☐ Latex
☐ Soy
☐ Insect Stings
☐ Fish/Shellfish
☐ Chemicals _____
☐ Vapors _____
☐ Tree Nuts (walnuts, pecans, etc)
☐ Other: _____

b. Age of student when allergy first discovered: _____
c. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain:
_____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ☐ Same ☐ Better ☐ Worse (for each proceeding episode)

3. Trigger and Symptoms

_____

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? __secs. ____mins.____hrs.____days

d. Please check the symptoms that your child has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough

Lungs: ☐ Shortness of breath ☐ Repetitive cough ☐ Wheezing

Heart: ☐ Weak pulse ☐ Loss of consciousness

4. Treatment

a. How have past reactions been treated? ☐ Benadryl ☐EpiPen
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ☐No ☐Yes, explain: _____
d. Was the student admitted to the hospital? ☐No ☐Yes, explain: _____

_____

e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

_____

f. Has your healthcare provider provided you with a prescription for medication? ☐No ☐ Yes
g. Have you used the treatment or medication? ☐ No ☐ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. Self-Care

a. Is your student able to monitor and prevent their own exposures? ☐ No ☐ Yes
b. Does your student:

1. Know what foods to avoid	☐ No	☐ Yes
2. Ask about food ingredients	☐ No	☐ Yes
3. Read and understands food labels	☐ No	☐ Yes
4. Tell an adult immediately after an exposure	☐ No	☐ Yes
5. Wear a medical alert bracelet, necklace, watchband	☐ No	☐ Yes
6. Tell peers and adults about the allergy	☐ No	☐ Yes
7. Firmly refuses a problem food	☐ No	☐ Yes

6. General Health

a. How is your child's general health other than having a food allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of asthma? ☐ No ☐ If yes, does he/she have an Asthma Action Plan? ☐ No ☐ Yes

Please add anything else you would like the school to know about your child's health: _____

Please Review the following:

- I hereby request and authorize the school nurse, health aide, or other school personnel to administer the medical procedures authorized by the physician named above to the Student.
- I agree to furnish all medications or other items necessary for the administration of the services.
- I agree to notify the School Health Office immediately if there are any changes in the Student's medical condition or physician's orders that impact the School's responsibilities to the Student or that may impact the Student during the school day.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition
- Signing this form shall release the Higley Unified School District and its employees from liability of any nature that might result from this plan of action.
- I also acknowledge that the emergency plan of action will most likely be administered by trained, unlicensed Higley Unified School District personnel.

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by HUSD Health Aide: _____ **Date:** _____

Severe Allergic Reaction (Anaphylaxis) Bus Plan

Student Name: _____ Teacher: _____
Year: _____
Route:

Signs that may be present: Check all that apply:
☐ Itching and Swelling of Lips ☐ Swelling of Tongue or Mouth ☐ Tightness of Throat

☐ Coughing or Wheezing ☐ Hives ☐ Itching ☐ Nausea or Vomiting ☐ Fainting

☐ Other:

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1. **Call 911**: Let them know you have a child with a severe allergic reaction
2. **Location of Epinephrine Device:** _____
3. Administer epinephrine device to upper outer thigh
    a. Follow device instructions
    b. Document time epinephrine was administered
    c. Give injector to EMS personnel
4. Monitor student closely
5. If breathing stops **Start CPR!**

Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/Guardian Signature_____Date:_____

Nurse/Health Aide Signature _____Date:_____