



Name: _____ D.O.B.: _____

Allergic 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

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. **ADMINSTER 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 (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 2mg IN (intranasal)

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

☐ Patient may self-carry ☐ Patient may self-administer

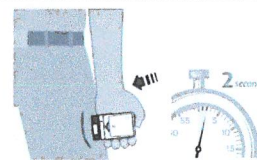


FARE.
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

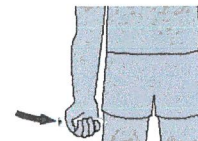
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



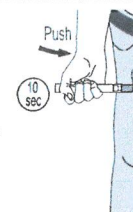
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALINE®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



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: _____

**WARDLAW+HARTRIDGE SCHOOL 20__-20__ Page 3 of 4 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 Section only*****

to list epinephrine auto-injector trained delegates

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+Hartridge School/ employees or school nurse/s, nurse's agent/nurse//nurse-employers/MOESC/third party hired nurse/dually employed nurse, 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 that the school nurse trains and approves volunteer delegates based on state codes. A delegate can give an epinephrine pre-filled auto-injector if the nurse is unavailable. **I am aware I must notify the 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/Neffy sprays. 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 the 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 nurses or school authorities.

Student name _____

Parent or Guardian name (print) _____

Parent or Guardian Signature _____

Date _____

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 employee/nurse, and/or MOESC nurse/third party hired school nurse/ or dually employed nurse, shall be responsible for any liability as a result of any injury arising from the self-administration 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 auto-injector 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

Physician's Stamp

Telephone #

date

Neither the W+HS, nor any employee/nurse(s), nurse's agents/nurse-employers/MOESC/third party hired nurse/dually employed nurse, shall be responsible for any liability as a result of injury to the above-named student, arising from the self-administration 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 the 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, and 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. Students 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/s with questions.

We agree to indemnify and hold harmless the Wardlaw+Hartridge School, its employees/agents/nurse/s, nurse’s employer(s) agents, MOESC/third-party hired nurse/dually employed nurse from any claims arising from failure of parent or student to follow 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_____

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 the 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 physicians. 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/s, nurse's agent/nurse-employers/MOESC/third party hired nurse/dually employed 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