

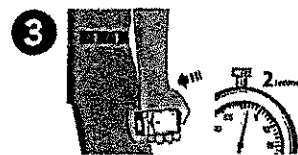


FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

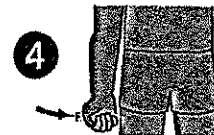
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



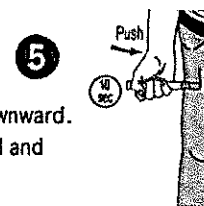
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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. 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.



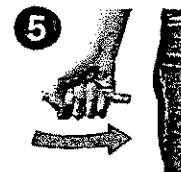
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



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: _____

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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. **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): _____

INFORMATION FOR SCHOOL MANAGEMENT OF DIABETES MELLITUS

School Year: _____

Student's Name: _____ Date of Birth: _____ Effective Date: _____

School Name: _____ STUDENT ID: _____ Grade: _____

CONTACT INFORMATION:

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Parent/Guardian #1: _____ Phone #: Home: _____ Work: _____ Cell/Pager: _____

Diabetes Care Provider: _____ Phone #: _____

Other emergency contact: _____ Relationship: _____

Phone Numbers: Home: _____ Cellular/Pager: _____

Insurance Carrier: _____ Preferred Hospital: _____

EMERGENCY NOTIFICATION: Notify parents of the following conditions:

- a. Loss of consciousness or seizure (convulsion) immediately after calling 911 and administering Glucagon.
- b. Blood sugars in excess of 300 mg/dl. With ketones present
- c. Positive urine ketones.
- d. Abdominal pain, nausea/vomiting, fever, diarrhea, altered breathing, altered level of consciousness

STUDENT'S COMPETENCE WITH PROCEDURES: (Must be verified by parent and school nurse)

- | | |
|--|--|
| ☐ Blood glucose monitoring | ☐ Carry supplies for BG monitoring |
| ☐ Determining insulin dose | ☐ Carry supplies for insulin administration |
| ☐ Measuring insulin | ☐ Monitor BG in classroom |
| ☐ Injecting insulin | ☐ Self treatment for mild low blood sugar |
| ☐ Independently operates insulin pump | ☐ Determine own snack/meal content |

MEAL PLAN: Time Location CHO Content Time Location CHO Content

- | | |
|---------------------------------------|--|
| ☐ Bkft _____ | ☐ Mid-PM _____ |
| ☐ Mid-AM _____ | ☐ Before PE _____ |
| ☐ Lunch _____ | ☐ After PE: _____ |

Meal/snack will be considered mandatory. Times of meals/snacks will be at routine school times unless alteration is indicated. School nurse will contact diabetes care provider for adjustment in meal times. Content of meal/snack will be determined by:

☐ Student ☐ Parent ☐ School nurse ☐ Diabetes provider

Please provide school cafeteria with a copy of this meal plan order to fulfill USDA requirements.

Parent to provide and restock snacks and low blood sugar supplies box.

LOCATION OF SUPPLIES/EQUIPMENT: (To be completed by school personnel)

Blood glucose equipment: ☐ Clinic/health room ☐ With student

Insulin administration supplies: ☐ Clinic/health room ☐ With student

Glucagon emergency kit: _____ Glucose gel: _____ Ketone testing supplies: _____

Fast acting carbohydrate: ☐ Clinic/health room ☐ With student Snacks: ☐ Clinic/health room ☐ With student

SIGNATURES: I understand that all treatments and procedures may be performed by the student and/or unlicensed personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I give permission for school personnel to contact my child's diabetes provider for guidance and recommendations. I have reviewed this information form and agree with the indicated information. This form will assist the school in developing a health plan and in providing appropriate care for my child.

PARENT SIGNATURE: _____ DATE: _____

COUNTY SCHOOL NURSE SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER AUTHORIZATION FOR SCHOOL MANAGEMENT OF DIABETES

STUDENT: _____ DOB: _____ DATE: _____

BLOOD GLUCOSE (BG) MONITORING: (Target range: _____ mg/dl to _____ mg/dl.)

- ☐ Before meals
☐ PRN for suspected low/high BG ☐ 2 hours after correction
☐ Midmorning ☐ Mid-afternoon

INSULIN ADMINISTRATION: Dose determined by: ☐ Student ☐ Parent ☐ School nurse

Insulin delivery system ☐ Syringe ☐ Pen ☐ Pump (Use supplemental form for Student Wearing Insulin Pump)

BEFORE MEAL INSULIN:

Insulin Type: ☐ Humalog ☐ Novolog ☐ _____ Other

- ☐ Insulin to Carbohydrate Ratio: _____ unit(s) per _____ grams carbohydrate
☐ Give _____ units

CORRECTION INSULIN for high blood sugar (Check only those which apply)

☐ Use the following correction formula: BG - _____ / _____ (for pre lunch blood sugar over _____)

- ☐ Sliding Scale:
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u
 BG from _____ to _____ = _____ u

Add before meal insulin to correction/ sliding scale insulin for total meal time insulin dose

MANAGEMENT OF LOW BLOOD GLUCOSE :

MILD: Blood Glucose < _____

SEVERE: Loss of consciousness or seizure

- ☐ Never leave student alone
☐ Give 15 gms glucose; recheck in 15 min.
☐ If BG < 70, retreat and recheck q 15 min x 3
☐ Notify parent if not resolved.
☐ Provide snack with carbohydrate, fat, protein after treating and meal not scheduled > 1 hr
- ☐ Call 911. Open airway. Turn to side.
 Glucagon injection ☐ 0.25 mg ☐ 0.50 mg ☐ 1.0 mg IM/SQ
☐ Notify parent.

MANAGEMENT OF HIGH BLOOD GLUCOSE (Above _____ mg/dl)

- ☐ Sugar-free fluids/frequent bathroom privileges.
☐ If BG is greater than 300, and it's been 2 hours since last dose, give ☐ HALF ☐ FULL correction formula noted above.
☐ If BG is greater than 300, and it's been 4 hours since last dose, give FULL correction formula noted above.
☐ If BG is greater than 300 check for ketones. Notify parent if ketones are present.
☐ Note and document changes in status.
☐ Child should be allowed to stay in school unless vomiting and moderate or large ketones are present.

EXERCISE:

Faculty/staff must be informed and educated regarding management. Staff should provide easy access to fast-acting carbohydrates, snacks, and BG monitoring equipment during activities. Child should NOT exercise if blood glucose levels are below 70mg/dl or above 300 mg/dl and urine contains moderate or large ketones.

- ☐ Check blood sugar right before PE to determine need for additional snack.
☐ If BG is less than 70 mg/dl, eat 15-45 grams carbohydrate before, depending on intensity and length of exercise.

☐ Student may disconnect insulin pump for 1 hour or decrease basal rate by _____.

My signature provides authorization for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

☐ If changes are indicated, I will provide new written authorized orders (may be faxed).

☐ Dose/treatment changes may be relayed through parent.

Healthcare Provider Signature: _____ Date: _____

Address: _____ Telephone: _____

SEIZURE ACTION PLAN (SAP)



ENDEPILEPSY

Name: _____ Birth Date: _____
Address: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☒

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked



When rescue therapy may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____



Asthma and Allergy
Foundation of America

STUDENT ASTHMA ACTION CARD



National Asthma Education and
Prevention Program



Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

ID Photo

Emergency Phone Contact #1	Name	Relationship	Phone
Emergency Phone Contact #2	Name	Relationship	Phone

Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as, _____, _____, _____, _____ or has a peak flow reading of _____.

• Steps to take during an asthma episode:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____

4. Re-check peak flow.

5. Seek emergency medical care if the student has any of the following:

- ✓ Coughs constantly
- ✓ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
- ✓ Peak flow of _____
- ✓ Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Stooped body posture
 - Struggling or gasping
- ✓ Trouble walking or talking
- ✓ Stops playing and can't start activity again
- ✓ Lips or fingernails are grey or blue

**IF THIS HAPPENS, GET
EMERGENCY HELP NOW!**

• Emergency Asthma Medications

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

See reverse for more instructions

DAILY ASTHMA MANAGEMENT PLAN

• Identify the things which start an asthma episode (Check each that applies to the student.)

- | | | |
|---|--|--------------------------------------|
| ☐ Exercise | ☐ Strong odors or fumes | ☐ Other _____ |
| ☐ Respiratory infections | ☐ Chalk dust / dust | _____ |
| ☐ Change in temperature | ☐ Carpets in the room | |
| ☐ Animals | ☐ Pollens | |
| ☐ Food _____ | ☐ Molds | |

Comments _____

• Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

• Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____

• Daily Medication Plan

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

COMMENTS / SPECIAL INSTRUCTIONS

FOR INHALED MEDICATIONS

- ☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.
- ☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature

Date

Parent/Guardian Signature

Date

BULLOCH ACADEMY

Authorization for Student to Carry Prescription Inhaler or Epipen

_____ need to carry the following prescription-labeled inhaler or epipen with him/her. The above -named student has been instructed in the proper use of the medication and fully understands how to administer this medication. It is preferable that a backup be kept in the school clinic.

_____ (med, dosage, instructions)

Physician Signature: _____ Date _____

I request that the above-named student be allowed to carry and use the prescription medication at school. I accept legal responsibility should the medication be lost, given, or taken by another person other than the above-named student. I understand that should this happen, the privilege of carrying the medication may be revoked and my child may be subject to disciplinary action. I release Bulloch Academy and its employees of any legal responsibility when the above named student administers his/her own medication. I also accept responsibility for instructing said student to check in with the nurse to keep her informed of use of my medication, in case I start having problems.

Parent/Guardian _____ Date: _____

I have been instructed in the proper use of my medication. I will not let another student use my medication while on campus or at any off campus function. I understand that I will be subject to disciplinary action if I do and that the privilege of carrying said medication might be revoked. I also will check in with the nurse to keep her informed of using the medication, in case I start having problems.

Student signature _____ Date _____

Bulloch Academy

Authorization for Medication Administration or Health Procedure/Treatment
(Please complete one for each medication/procedure/treatment)

Student name _____ DOB _____

Doctor's Name: _____

Medication (Name and Dosage) _____

Procedure/Treatment: _____

Time(s) to be administered at school _____

Start Date: _____ End Date _____

Time and Dosage Medication/Procedure/Treatment Administered at home: _____

I request and authorize the school nurse or designee at Bulloch Academy to administer the above medication/procedure/treatment to my child. I agree to provide a physician's order now and a new order if there is any change in medication/procedure/treatment. I agree to deliver the medication to the school nurse's office or her designee.

Parent/Guardian: _____ Date _____

Phone _____

Physician Signature: _____

Date and Time: _____ Phone: _____