



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. **ADMINISTER 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 ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

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

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

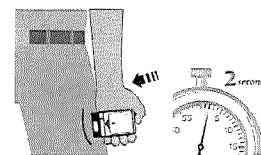
DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

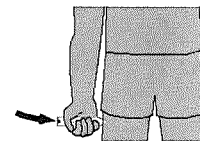
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



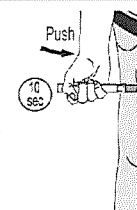
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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.



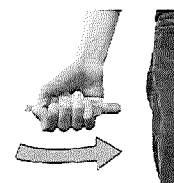
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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.



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: _____



Authorization to Administer Prescription and Non-Prescription Medication

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Medication: _____ Dosage: _____ Route: _____ Time: _____

Reason for Medication: _____ Start Date: ____/____/____ End Date: ____/____/____

THIS SECTION IS REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

Physician Signature/Or Copy of Current Prescription Label

I have prescribed the medication(s) listed above and authorize the school nurse or the principal's designee to administer them as prescribed, with time adjustments to accommodate lunches, late arrivals, early dismissals, etc.

Physician Signature
Must be signed for the student to self-carry (e.g., inhaler, EpiPen)

This student has demonstrated the ability to follow instructions regarding the safe and appropriate use of this emergency medication and should be permitted to carry it. Controlled substances are NOT permitted to be carried by students.

Please send the following medication(s) home with the student at the end of the school year.

Controlled substances **WILL NOT be sent home with the student. Controlled substances must be picked up by a parent, guardian, or an adult who is at least 18 years of age, with written permission from the parent or guardian.*

☐ Benadryl ☐ Epinephrine (Auvi-Q, EpiPen, Neffy, etc.) ☐ Inhaler

PARENT AGREEMENT/AUTHORIZATION:

- I authorize the school nurse and/or the principal's designee to administer the prescribed medication to my child as prescribed/directed by a licensed healthcare provider.
- I understand that it is the parent's/guardian's responsibility to supply the medication in its original, properly labeled container. **Prescription medications must have a pharmacy label.**
- I agree to replace any medication before or by the expiration date.
- I understand that any changes to the medication, dosage, or administration frequency require a new Authorization to Administer Medication form, including a physician's signature or updated pharmacy label (*for prescription medications*).
- A new Authorization to Administer Medication form must be submitted each school year.
- Students are not permitted to carry or transport medications without a current Authorization to Administer Medication form on file.
- Medications not picked up by the end of the school year will be properly disposed of.
- I agree to notify the school nurse or principal's designee if the medication should not be administered for any reason (e.g., late arrival, early dismissal, discontinuation).

Parent/Guardian Name (*printed*): _____

Parent/Guardian Signature: _____

Date: _____



Physician Authorization to Self-Carry Emergency Medication at School

I have diagnosed _____
(Student's Name)

with _____
(Name of Chronic Disease)

for which emergency medication _____ may be needed
(Name of Medication)

while at school or during school sponsored activities.

I have instructed this patient on how to safely and appropriately use this medication, and I believe they are capable of following these instructions. I also believe this patient should carry the medication and use it responsibly, in accordance with my orders and instructions.

Physician Name (*printed*): _____

Physician Signature: _____ Date: _____



Accommodations for Special Dietary Needs

Duneland School Corporation adheres to specific United States Department of Agriculture (USDA) guidelines in providing special dietary accommodations for students. A "reasonable modification" is a change or alteration in practices or procedures to accommodate a disability that ensures that all students have equal opportunity to participate in or benefit from the program. In accordance with the criteria set forth in 7 CFR Part 15b, those students who are unable to eat the school meal as is due to a disability, medical need, and/or impairment are accommodated at no additional charge. Meal modifications must be related to the disability or limitations caused by the disability. The USDA regulations for school nutrition programs does not require meal modifications for children whose special dietary needs do not constitute a disability, including those related to religious or moral convictions, general health concerns, and personal food preferences.

Per Section 504 of the Rehabilitation Act of 1973, parents/guardians have a right to an evaluation of their student if the district has reason to believe that the student has a mental and/or physical impairment that substantially limits a major life activity, which can involve eating/digestion. Students have the right to this evaluation before any plan for accommodation. Parents/guardians should ensure that they contact the school if they feel as though an evaluation would be appropriate.

Parents/guardians should complete the necessary information on the medical statement form to request an accommodation for their student. The school may contact the student and parents/guardians for additional information as needed. For example, if the substitutions needed for accommodations fall outside of the USDA meal pattern, the form must be signed by an authorized medical authority with prescriptive privileges in the state of Indiana.

Procedural Safeguards

If the household feels that reasonable accommodations are not being met, they have the right to contact the school's 504 Coordinator and:

- File a grievance if they believe a violation has occurred regarding the request for a reasonable modification;
- Receive a prompt and equitable resolution of the grievance;
- Request and participate in an impartial hearing to resolve their grievances;
- Be represented by counsel at the hearing;
- Examine the record; and
- Receive notice of the final decision and a procedure for review, i.e., right to appeal the hearing's decision.

Accommodations Coordinator

The safety of your child comes first. If you have a child with a disability, medical need, or impairment, please submit your request for accommodation by completing this form and submitting it to: **the School Nurse at your child's school.**

For more information about accommodations for meals and the meal service for students with disabilities, please contact: **Tonia Batesole, Director of Child Nutrition** at tbatesole@duneland.k12.in.us.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. *mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;*
2. *fax: (202) 690-7442; or*
3. *email: program.intake@usda.gov.*

This institution is an equal opportunity provider.

DUNELAND

HEALTH SERVICES

Duneland School Corporation participates in a federally funded Child Nutrition Program. All meals and/or milk served must meet the requirements of this program. A reasonable meal accommodation will be provided when the request is related to a documented disability or impairment.

If you are requesting a meal accommodation or substitution, please have this form completed and signed by both a healthcare provider with prescriptive authority in the state of Indiana or a Registered Dietitian and a parent or guardian. Return the completed form to the school nurse at your child's school.

If you have any questions or concerns, please contact **Tonia Batesole, Director of Child Nutrition**, at (219) 983-3700 or via email at tbatesole@duneland.k12.in.us.

USDA is an equal opportunity provider, employer, and lender.

Student's Name: _____

Date of Birth: _____

School Name: _____

Grade: _____

Parent's Name: _____

Phone Number: _____

Food(s) to Omit	Food(s) to Substitute

To be signed by a healthcare provider or a Registered Dietitian:

Healthcare Provider's/Registered Dietitian's Name

Healthcare Provider's/Registered Dietitian's Signature

Date: _____

Parent/Guardian's Name (Print)

Parent/Guardian's Signature

Date: _____

Signing the following section is optional but may prevent delays by allowing school personnel to speak with the healthcare provider and/or Registered Dietitian:

Health Insurance Portability and Accountability Act Waiver (HIPPA)

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act (FERPA), I hereby authorize (medical authority) to release such protected health information of my child as is necessary for the specific purpose of special diet information to (school/program), and I consent to allow the medical authority to freely exchange the information listed on this form and in their records concerning my child, with the school program, as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. This information is to be released for the specific purpose of special diet information. The undersigned certifies that he/she is the parent, guardian, or representative of the child listed on this document and has the legal authority to sign on behalf of that child.

Parent/Guardian Signature: _____ Date: _____