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

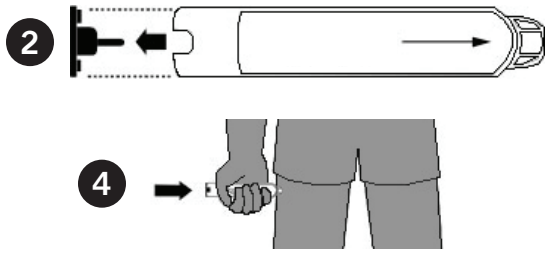
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 4/2014

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

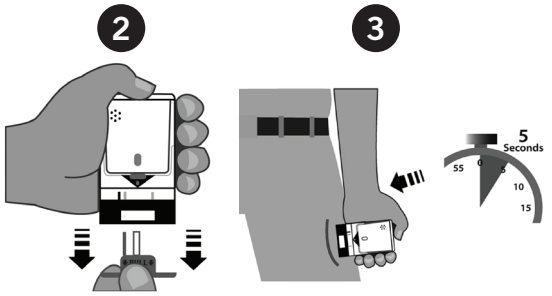
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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

Physician Authorization Form
For Epinephrine Autoinjector

Student's Name_____ Date of Birth_____

Student's Address_____ Phone_____

School Branch_____ Grade_____

Medication to be administered

Does this medication have a generic name? _____

Dosage to be administered_____

Time/ interval when to be administered:_____

Date to begin administration_____ Date to Cease administration_____

Possible adverse reactions or side effects_____

List of severe reactions that should be reported to the physician_____

_____

Special instructions for storage of medication_____

Special instructions for administration of medication_____

Physician's Name_____ Phone_____

Address _____ Emergency Phone_____

_____ _____

Physician's Signature**_____ Date_____

**My signature on this form confirms that I have determined the student is capable of possessing and using the epinephrine autoinjector appropriately and that I have provided the student with training in the proper use of the autoinjector.

****

I give my permission for Tree of Life Christian Schools to administer the ***prescription medication*** listed above to my child _____ (child's name) at the time and dosage stated by the physician.

- I understand it is my responsibility to send an appropriate supply of medication I want Tree of Life to administer to my child during the current school year in its ***original container with my child's name on it***. This should be turned in to the front office. NO medication is permitted in book bags and/or lockers (**).
- The school reserves the right to prohibit the administration of any medications or procedures that appear to be beyond the ability of school personnel.
- The prescription medication for the student listed above cannot be scheduled for other than school hours. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medicine or with any changes to the information provided on this form.
- The school will keep a written account of medication administered to my child in school throughout the current school year.
- I do hereby release Tree of Life Christian Schools and any persons, employees, etc. designated by Tree of Life Christian Schools from and against any and all claims, demands or causes of action by any person for loss, cost, injury or damage alleged to rise from or out of the administration of medical services as requested above and authorized below.

Parent's/Guardian's signature_____ Date_____

** Ohio state law permits students to carry metered dose or dry powder asthma inhalers and/or epipens approved by the student's physician and parents. If you are giving permission for your child to carry his/her inhaler and/or epipen on school premises or to school functions rather than keeping it in the school office, **please initial here**. _____

(Revised 2014, Reviewed 2016)