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): _____

_____

Parent/Guardian Authorization Signature Date Physician/HCP Authorization Signature Date

Fax completed form to 763-241-3410

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

Parent/Guardian: Complete this page

Student _____ Date of Birth_____ School _____ Grade_____

BUS INFORMATION: It is the parent's responsibility to notify the bus company directly of any specific directions for your child's care while riding the bus.

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
6. I understand that this action plan my be revoked at any time in writing and expires in one calendar year.
7. I authorize the above plan to be followed in school.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: _____ Relationship to Student: _____ Date: _____

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature: _____ Date: _____

SELF-CARRY EPINEPHRINE CONTRACT

Based on student's knowledge and skills to safely possess, per Licensed School Nurse's discretion

I give permission for my child, _____ to carry their epinephrine. My child understands that they must never share their epinephrine with others and that they must go to Health Services immediately after use of epinephrine. I will notify the school of changes in medication or my child's condition. **Note: It is recommended to have a back-up epinephrine that is kept in Health Services.**

Parent/Guardian Signature: _____ Date: _____

STUDENT AGREEMENT

I agree to:

- ☐ Follow my prescribing physician's medication orders.
- ☐ Use correct medication administration technique.
- ☐ Not allow anyone else to use my medication.
- ☐ Keep a supply of my medication with me in school and on field trips.
- ☐ Notify health office personnel if my epinephrine is administered and 911 will be called.

Student signature: _____ Date: _____

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