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 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: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

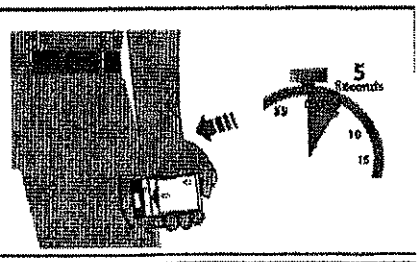
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Food Allergy Research & Education

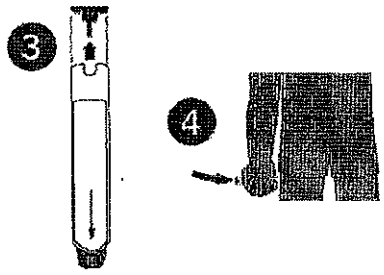
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



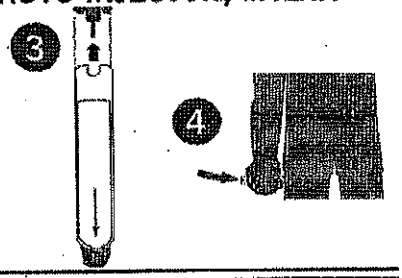
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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



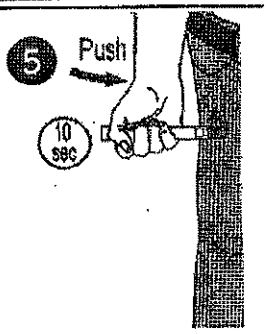
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. 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.

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: _____

Administration of Medication Form

FORT THOMAS INDEPENDENT SCHOOL DISTRICT

Robert D. Johnson Elementary
441-2444 fax: 572-4948

Ruth Moyer Elementary
441-1180 fax: 441-9440

Samuel Woodfill Elementary
441-0506 fax: 441-2755

Highlands Middle School
441-5222 fax: 441-4210

Highlands High School
781-5900 fax: 442-4212

Dear Parent or Guardian:

If your child requires medication, if possible, please try to schedule it before or after school hours. If the medication is to be given during school hours, we must have this form completed and signed by you and your child's physician. Your doctor may fax this form to the school office. The duration of this form is for one (1) school year only.

SCHOOL YEAR_____

Name:_____ Date of Birth_____

Grade:_____ Allergies:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

****For inhaler, Epipen, FDA approved seizure rescue medication, and/or Glucagon, the student has received training to carry the inhaler or emergency medication and may carry and self-administer this medication. ☐ YES ☐ NO

****For field trips, the student has received training and may carry and self-administer the medication/s listed above. ☐ YES ☐ NO

I give permission for the administration of this medication/s by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication/s. School officials may need to contact the ordering physician if additional information is needed. I hereby authorize release of any needed information from the ordering physician regarding this medication. Student may self-administer the above medication/s with school trained personnel supervision while on a field trip. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary.

Parent/Guardian Signature	Parent's Phone	Date
Physician's Signature	Physician's Phone	Date
Print Physician's Name	Physician's Address	Fax Number

For student health services/procedures not involving medication only, please refer to 09.22 AP.22.

REVIEW/REVISED:7/11/2016

National Association of School Nurses

Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?
- ❑ Peanuts
- ❑ Eggs
- ❑ Milk
- ❑ Latex
- ❑ Soy
- ❑ Other: _____
- ❑ Insect Stings
- ❑ Fish/Shellfish
- ❑ Chemicals _____
- ❑ Vapors _____
- ❑ Tree Nuts (walnuts, pecans, etc.)

b. Age of student when allergy first discovered: _____
c. How many times has student had a reaction?
❑ Never ❑ Once ❑ More than once, explain: _____
d. Explain their past reaction(s): _____
e. Symptoms: _____
f. Are the food allergy reactions: ❑ Same ❑ Better ❑ Worse

3. Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days

d. Please check the symptoms that your child has experienced in the past:

Skin:	❑ Hives	❑ Itching	❑ Rash	❑ Flushing	❑ Swelling (face, arms, hands, legs)
Mouth:	❑ Itching	❑ Swelling (lips, tongue, mouth)			
Abdominal:	❑ Nausea	❑ Cramps	❑ Vomiting	❑ Diarrhea	
Throat:	❑ Itching	❑ Tightness	❑ Hoarseness	❑ Cough	
Lungs:	❑ Shortness of breath		❑ Repetitive Cough		❑ Wheezing
Heart:	❑ Weak pulse	❑ Loss of consciousness			

4. Treatment

a. How have past reactions been treated? _____
b. How effective was the student's response to treatment? _____
c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____
e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____
f. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
g. Have you used the treatment or medication? ❑ No ❑ Yes
h. Please describe any side effects or problems your child had in using the suggested treatment: _____

5. Self Care

a. Is your student able to monitor and prevent their own exposures? ❑ No ❑ Yes

b. Does your student:

1. Know what foods to avoid ❑ No ❑ Yes
2. Ask about food ingredients ❑ No ❑ Yes
3. Read and understands food labels ❑ No ❑ Yes
4. Tell an adult immediately after an exposure ❑ No ❑ Yes
5. Wear a medical alert bracelet, necklace, watchband ❑ No ❑ Yes
6. Tell peers and adults about the allergy ❑ No ❑ Yes
7. Firmly refuses a problem food ❑ No ❑ Yes

c. Does your child know how to use emergency medication? ❑ No ❑ Yes _____

d. Has your child ever administered their own emergency medication? ❑ No ❑ Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's food allergy? _____

b. Does your child carry epinephrine in the event of a reaction? ❑ No ❑ Yes

c. Has your child ever needed to administer that epinephrine? ❑ No ❑ Yes

d. Do you feel that your child needs assistance in coping with his/her food allergy? _____

7. General Health

a. How is your child's general health other than having a food allergy? _____

b. Does your child have other health conditions? _____

c. Hospitalizations? _____

d. Does your child have a history of asthma? ❑ No ❑ Yes

If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes

e. Please add anything else you would like the school to know about your child's health: _____

_____

8. Notes:

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by R.N.: _____ **Date:** _____

Adapted with permission – Washington State Guidelines for Anaphylaxis

FORT THOMAS INDEPENDENT SCHOOLS
EMERGENCY MEDICATION ADMINISTRATION
DURING EXTRACURRICULAR ACTIVITIES

Student Name: _____
Grade: _____
Date:_____

Please list any sports/extracurricular activities that your child will be participating in during the school
year:_____

I, _____, parent of_____,
am aware that my child may require the administration of _____ in an emergency situation that occurs before or after normal school hours. I agree to inform the school nurse that my child will participate in extracurricular activities and to inform the coach, leader or responsible adult for these extracurricular activities of my child's condition. **I will supply additional necessary emergency medications or supplies to coaches/leaders for use during these activities.** The school nurse will make available the necessary training to coaches/leader in the administration of these medications. If emergency medication administration is required, 911 will also be called.

If I do not make the medications available, I understand and agree that only 911 will be called in the event of an emergency.

If my child adds additional activities during the school year, I agree to notify the school nurse and coaches/leaders or responsible adult for these extracurricular activities of my child's condition.

_____ _____
(Signature of parent/guardian) *(Date)*