



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

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): _____

(Give copy to Bus driver if applicable)



FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

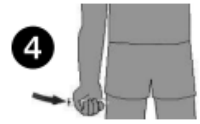
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



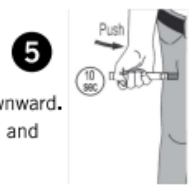
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENALICK®), 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: _____

(Give copy to Bus driver if applicable)

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form (**Request for Medication Administration in School**) from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over the counter drugs, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the doctor's written instructions.
(Please see and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: In accordance with G.S. 115C-375.2 and G. S. 115C-47, students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to the students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse at the following number: _____.

Thank you for your cooperation,

School Nurse

Date

Director

Date

The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (Request for Medication Administration in School). Return completed form to school. A separate parent request/permission form must be completed for each medication given at school.
3. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
 - a. Name of child
 - b. Name of medication
 - c. Date it was prescribed
 - d. Dosage
 - e. How the medicine is to be given at school
 - f. When the medicine will be given at school
 - g. Special instructions about the child receiving the medication or about the medicine itself.
 - h. Until what date the medicine is to be given at school
 - i. Possible side effects of the medication
 - j. Possible adverse reactions to the medication
 - k. Name of the health care provider and how to locate or communicate with him or her if necessary
4. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

5. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
6. Provide the school with new, labeled containers when dosage or medication changes are prescribed.
7. Retrieve all unused medications from school when medications are discontinued, and /or at end of school year (according to local written policy)
8. Maintain communication with the school staff regarding any changes in the medical treatment needed at school.

Parent Signature

Date

Health Office Representative

Date

ARISTOTLE

PREPARATORY ACADEMY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

Contraindications to administration: _____

Physician (printed) Name: _____ Address: _____

Physician Contact Information: Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

**This form is invalid unless stamped and signed by the healthcare provider*

Physician's Stamp Here

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Aristotle Preparatory Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____ Date: _____

Please document medication count *with parent present* below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

ARISTOTLE

PREPARATORY ACADEMY

Medication Administration Record

Student Name: _____ Medication: _____

A separate sheet is used for each medication or treatment

Key: A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
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Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

ARISTOTLE

PREPARATORY ACADEMY

Student Agreement for Self-Carried Medication

Student: _____ Grade: _____ Campus: _____

Parent(s) Printed name: _____

Parent(s) Contact Numbers: _____

Health Care Provider: _____ Phone Number: _____

Medication: _____ Dose and Time: _____

FOR PROVIDER

☐ Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.

Asthma ____ MDI (Metered Dose Inhaler) ____ MDI with spacer ____

Allergic reaction ____ Epinephrine ____ Auvi-Q ____

Diabetes ____ Insulin ____ Glucose ____

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C-375.2 The student also must have this self-medication agreement on file. The student's name must appear on medications and devices.

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.

Student Responsibilities

- *I will keep my inhaler/equipment, Epinephrine Auto Injector, or diabetes medication/equipment with me at school.*
- *I agree to use my inhaler/equipment, Epinephrine Auto-Injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care providers' orders.*
- *I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition*
- *I will not allow any other person to use my medication or equipment.*

Student Signature: _____ Date: _____

____ Emergency Action Plan complete and on file at school

____ Demonstrates correct use/administration

____ Verbalizes proper and prescribed timing for medication

____ Agrees to carry medication

____ Can describe own health condition well

____ Keeps a second labeled container in health office or main office

____ Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that Aristotle Preparatory Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Director Signature: _____ Date: _____

Physician Signature: _____ Date: _____