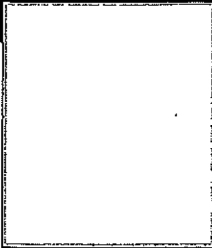
FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Food Allergy Research & Education



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: ______________

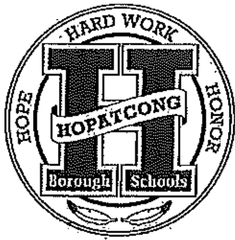
Antihistamine Dose: ______________

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

____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE & Stamp. DATE

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



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Hopatcong Borough Schools

Mr. Art DiBenedetto
Superintendent of Schools

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

To be completed by parent/guardian before any prescribed or over-the-counter medication, other than epinephrine or inhalers, may be administered in school.

Student ______________________________ School Year _______________

I request and consent to the administration of the following medication ___________________________ to my child by the school nurse or, in her absence, another registered nurse. This student would not be able to attend school if the medication is not administered during school hours.

I understand that the nurse and physician will communicate with one another as needed in order to safely and effectively carry out these medical orders. I further understand that this releases the school personnel from liability should a reaction result from the medication.

I understand that I must bring the medication to the school nurse in the original, labeled container from the pharmacy and that I am responsible for replacing the medication when it expires or when otherwise necessary. I agree to pick up any unused medication at the end of the school year, when the medication becomes outdated, or when the medication is no longer necessary, whichever comes first. I understand if I do not pick up the medication, it will be discarded.

I further understand that this releases all school personnel from liability should a reaction result from the medication.

I acknowledge that I have been informed that permission for administration of the medication will be effective only for the school year as indicated above, and that a new parent authorization and physician order is required every school year.

Date:______________________ Parent Signature:__________________________

PARENT LETTER: SELF ADMINISTRATION OF EPINEPHRINE FOR POTENTIALLY LIFE THREATENING ILLNESS

The Hopatcong Board of Education will permit students to carry and self-administer epinephrine by a student for potentially life threatening illness provided that:

1. The Food Allergy and Anaphylaxis Emergency Care Plan is filled out by the students Health care provider, is signed by the provider and is stamped.

2. PARENT CONSENT to self-administer is signed by parent and physician and stamped by the physician. (use this *IF* you want your child to carry and use their epi-pen independently). Medication must be kept in its original container with original pharmacy label attached and be kept in a secure place.

Permission is effective for the school year in which it is granted and must be renewed for each subsequent school year.
The district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and the parents or legal guardian shall indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising out of the self-administration of medication.

For your convenience, the required forms are attached to be completed by your health care provider and you. Should you have any question, please feel free to contact your child's school nurse.

High School Only

Hopatcong Borough Schools

Mr. Art DiBenedetto
Superintendent of Schools

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PARENT CONSENT

STUDENT NAME____

______I DO request that my child be ALLOWED to carry and self administer the following medication ________________________________ in school pursuant to N.J.A.C:.6A:16-2.1. I give permission for my child to carry and self-administer medication, as prescribed in this Food Allergy and Anaphylaxis Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container and be secured in such a manner that it is not available to other students. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

______I DO NOT request that my child carry or self-administer his/her epinephrine medication. I request the school nurse store and administer the medication prescribed according to the written instructions in the Allergy and Anaphylaxes Action Plan. I understand that the nurse and my physician will communicate with one another as needed in order to safely and effectively carry out these medical orders. I further understand that this releases the school personnel from liability should a reaction result from the medication.

Parent Print Name:____________________________________
Parent Signature:_____________________________________
Date:____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Permission to Self-administer Medication:

_______ This student may carry and is capable and has been instructed in the proper method of self-administering of epinephrine medications in accordance with NJ Law.

_______This student is not approved to carry and/or self-medicate

Physician Name:______________________________________

Physician Signature:___________________________________
Date:_____________________ Physician Stamp: