FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

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 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) 5/2014

FARE
Food Allergy Research & Education

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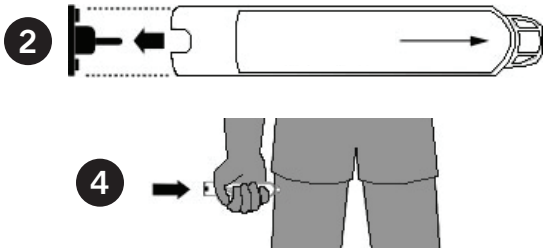
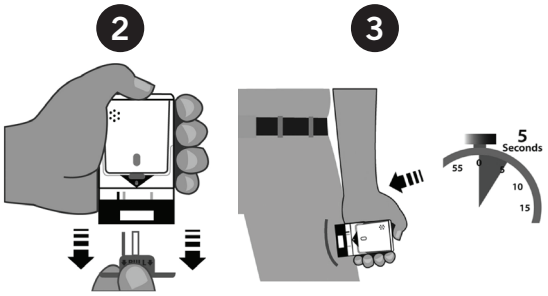
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 the person 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

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TO BE COMPLETED BY PARENT/GUARDIAN, STUDENT AND SCHOOL

Allergy/anaphylaxis Action Plan (cont) Student Name: _____ DOB _____

Parent/Guardian Authorizations :

☐ **I authorize the school nurse to share this information with faculty and staff, to implement the Allergy Action Plan, to administer medication, and to contact my daughter's health care provider as necessary.**

☐ **I understand that as the parent/guardian, it is my responsibility to contact the school nurse of any changes to the plan.**

☐ **I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.**

☐ **I understand the recommendation that backup medication be stored with the school/school nurse in the event a student forgets or misplaces her emergency medication(s) i.e.Epi-Pen; rescue inhaler**

Please check one box:

☐ I authorize my daughter to carry and self-administer her Epi-Pen if approved by the school nurse.	☐ I **DO NOT** authorize my daughter to carry and self- administer her Epi-Pen.

_____ _____ _____

Parent/Guardian Signature Date Emergency phone number(s)

Student Agreement:

☐ I have been trained in the use of my Epi-Pen and allergy medication and understand the signs and symptoms for which they are prescribed.

☐ I agree to carry my Epi Pen with me at all times.

☐ I will notify a responsible adult (nurse, teacher, coach, etc) IMMEDIATELY when Epi-pen is used.

☐ I will not share my medication with other students or leave my Epi-Pen unattended.

_____ _____

Student Signature Date

☐ Back-up medication is stored at school. ☐ YES ☐ NO

TRAINED STAFF MEMBERS

_____ _____ _____

_____ _____ _____

Directions for Epi-Pen Use

1. Pull off blue/gray safety cap.
2. Hold orange/black tip to outer thigh. (Always use outer thigh);
3. Press firmly against outer thigh until auto-injector mechanism functions and hold in place for 10 seconds.
4. Remove Epi-pen and massage injection site for 10 seconds.

* After Epi-Pen use, CALL 911/EMS.

6. Stay with student. Have student lie down and elevate legs as necessary.

* Call emergency contact. Name: _____ Phone _____

* Give allergy action plan and Epi-Pen to emergency responders.