FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

DURATION/ END DATE:

_____

SCHOOL YEAR

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 SIGNATURE **DATE**

PHYSICIAN/HCP SIGNATURE **DATE**

STAFFORD TOWNSHIP SCHOOL DISTRICT
PARENT PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____ (parent/guardian), hereby give permission to the SCHOOL NURSE and any TRAINED EPINEPHRINE DELEGATE to administer the above medication(s) to _____ (pupil's name) in accordance with District Policy.

By signing this form, I acknowledge and agree:

1) That I have received and reviewed Policy 5330 & 5331 as well as Regulation 5330 & 5331;
2) That I have been informed in writing that the Stafford Township School District shall incur no liability as a result of any injury arising from the administration of this medication to my child.
3) That I shall indemnify and hold harmless the District and its employees or agents against any injury or claims that may arise as a result of the administration of this medication.
4) That I am aware that if I desire to withdraw permission for any designee to administer medication, I must do so in writing.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Once completed, please make arrangements with the school nurse to drop off this form and your child's medication(s). The school nurse shall then review this form and forward to the Principal for completion. Please be advised that students cannot self-carry medication into school for delivery.

AUTHORIZATION - TO BE COMPLETED BY DISTRICT PERSONNEL

By signing this form, I acknowledge that I have received and reviewed all sections of this form and give my approval for administration of medication as set forth herein.

_____ _____

SIGNATURE OF SCHOOL PRINCIPAL **DATE**

_____ _____

SIGNATURE OF SCHOOL NURSE **DATE**

Once completed, the school nurse shall forward appropriate information to the Superintendent's office.