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 STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

⇩ ⇩ ⇩

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 asthmatic): _____

_____

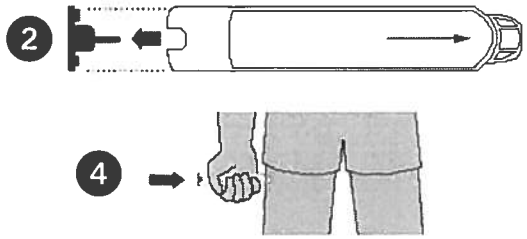
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

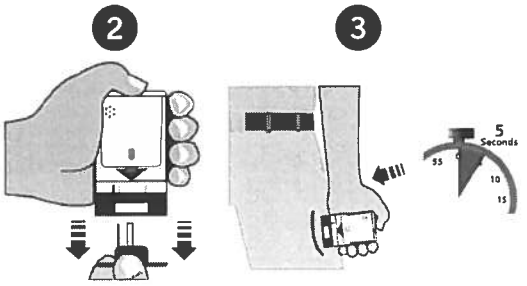
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 student 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 _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

Authorization for Self-Administration of Anaphylactic Medications at School

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

School Year Start Date: _____ (All authorizations expire at the end of the school year)

Medication orders & other Considerations / Directions: _____

_____

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use an epinephrine auto-injector.

☐ Student may self-administer the epinephrine auto-injector and/or an inhaler.

_____

Print Name of Physician Physician Signature

_____

Clinic Address Phone Number Date

Parent / Guardian Authorization

I request that the above medication(s) be used during school hours as ordered by this student's physician / licensed prescriber in case of severe allergic reaction that might lead to anaphylaxis. I also request the medication(s) be administered on field trips or other school sponsored activities, as prescribed.

I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s) (ex: medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's allergies which might lead to an anaphylactic reaction. In case of a severe allergic reaction, in addition to administration of either or both benadryl and epinephrine, 911 should be called as directed for standard treatment of anaphylaxis and parents notified immediately.

I give permission for the school nurse to consult with the above named student's physician / licensed prescriber regarding any questions that arise with regard to the listed medication(s).

☐ My son/daughter may self-administer his/her epinephrine device or medication used for an anaphylactic reaction.

_____

Parent/Guardian Name Signature Date

NOTE: Medication is to be supplied in the original container

Asthma & Allergy Foundation of America, Texas
www.aafatexas.org • info@aafatexas.org

Medical History for Life Threatening Food Allergies

Student _____ **Grade** _____ **Date** _____

Allergic to: _____ **Age of onset** _____

Doctor _____ **Phone Number** _____ **Fax Number**_____

1. What foods are problematic? _____
   a. Would consumption of the food to which this child is allergic/intolerant result in a life threatening food reaction? Y or N
   b. When was the last reaction? _____
   c. Describe the reaction: _____
      _____
   d. Has the student ever suffered a reaction at school or on the bus? Provide details if so:
      _____
   e. How long does the reaction last? _____
   f. Was a hospital visit required? Y or N
   g. Is an injection of Epinephrine required to stop the attack or reaction? Y or N
   h. What else will need to be done in the event of a severe reaction? _____
   i. How much time does the school have to respond to the reaction? _____

2. What kind of exposure causes the problem?
   a. Does it have to touch the student's skin? Y or N
   b. Does the student have to inhale the allergen for a reaction? Y or N
   b. Does the student have to ingest the food to trigger a reaction? Y or N
   c. How far away must the student remain from the allergen? _____
   d. What precautions do the parents use at home? _____ On vacation? _____
      In the community? _____

3. Is there a risk of death or serious illness? Y or N

Comments: _____

_____

_____

Leading the Way in the 21st Century
CLEAR CREEK INDEPENDENT SCHOOL DISTRICT

Clear Creek Independent School District
Student Diet Modification Request Form

Section I – Information **Student Information**

Name of Student (Last, First): _____ **Date of Birth:** _____

School: _____ **Grade:** _____

Reason for Diet Modification Request: _____

Parent/Guardian Contact Information:

Name: _____

Phone Number: _____ **Email:** _____

Diet Modification Request

☐ Student will be participating in the Child Nutrition Program – eating lunch or breakfast at school (If Yes is selected please go to **Section II**).

Please circle all that apply: Breakfast Lunch

☐ Student will not be participating in the Child Nutrition Program – eating lunch or breakfast at school and all food eaten by student will be supplied by parent/guardian.

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

Section II – Parent Consent

Parent/Guardian Consent to Release Student Information

I, _____ (parent/guardian), authorize the below-named physician to release health and dietary information regarding the above named student to Clear Creek Independent School District's Child Nutrition Department.

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

Physician Contact Information

Physician Name: _____ **Phone Number:** _____

Fax Number: _____

Clinic/Facility Name & Address: _____

_____

Note: Accommodations will only be made if there is a documented life- threatening food allergy or disability and will not be made until all documentation has been returned and approved. If approved, these accommodations are good for one year and will need to be renewed each year by the anniversary date of implementation in order to continue.

Nurse Checklist for Students with Life-Threatening Food Allergies

Student: _____ **Allergen:**_____ **School:**_____

Birthdate: _____ **Grade/Teacher:**_____

Purpose: To provide a safe environment, promote student food allergy self-management, recognize signs of anaphylaxis, and provide appropriate assistance and emergency care.

Activities to be reviewed:

Field trips – All treatment supplies are taken and care is provided:

____By accompanying parent or designee.

____By school staff trained in student's emergency care plan (ECP).

In the event of classroom/school parties, food treats will be handled as follows:

____Student will eat treat if ingredients listed are approved by parent.

____Parent supplies all snacks and treats for student.

After-school activities:

_____

Special eating arrangements:

_____

Activities student can self-manage:

Student responsibility:

____Will not trade food with others.

____Will not eat anything with unknown ingredients or known allergen.

____Will notify an adult immediately if eats something they believe may contain food allergen.

____Will wear a medic alert bracelet or dog tag necklace.

____Yes ____No: Will self-carry EpiPen with medical authorization form. Location: _____

Epinephrine injections:

____Yes ____No: Administers independently (trained/authorized by LHCP and reviewed by school nurse), if able to do so. Trained school staff should be available to supervise and observe.

____Yes ____No: Administration by nurse or trained staff. Location of medication: Clinic

Teacher Responsibilities:

____Know the FAAP/ECP and classroom accommodations.

____Know the location of all emergency information and medications.

____Be trained to administer EpiPen.

____Inform substitutes of FAAP/ ECP.

____Set up a plan for student to inform you if they are having a reaction.

____Help educate classroom about allergies.

____Send home to all parents Food Allergy Notification letter.

____Be prepared for special events, parties, field trips (contact parent prior to events).

____Instruct students not to share food and eating utensils.

____Ensure students maintain good hand washing techniques.

____Read contents of teaching materials such as science kits to identify potential allergens.

Parent Responsibilities:

____Provide EpiPen and/or other prescribed medications with the FAAP/ECP.

____Parent declines bringing EpiPen

____Inform nurse of any changes or allergic/anaphylactic episodes.

____Obtain a medic alert bracelet or dog tag style necklace for the student.

____Provide lunch from home (safest option).

____Complete physicians diet modification form for school prepared meals. ___yes ____no

____School menus will be previewed by parent and student to self select foods from school menu (be aware menu items change).

Nurse/School Responsibilities:

_____Complete FAAP/ ECP and attach to IHP.

_____Physician Diet Modification form initiated and forwarded to Child Nutrition. ____yes _____no

_____Review eating arrangements if needed, e.g., nut free area. ___yes ____no My child will eat in a nut free area.

_____Verify school bus driver received FAAP/ ECP and training if applicable. Bus number _____

_____Train school staff (awareness of allergens, allergic symptoms and FAAP/ ECP). C.A.R.E. power point viewed by all school staff.

_____Train school staff in location and administration of emergency medications/EpiPen.

I have read the items on the checklist and agree to implementation of by my child's school.

_____Parent/Guardian _____Nurse

WAIVER: Should I choose to NOT follow any or all of the guidelines listed, I release CCISD of liability should any harm come to my child as a result. _____Parent/Guardian Date_____