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 PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

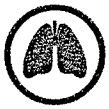
THEREFORE:

[ ] 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

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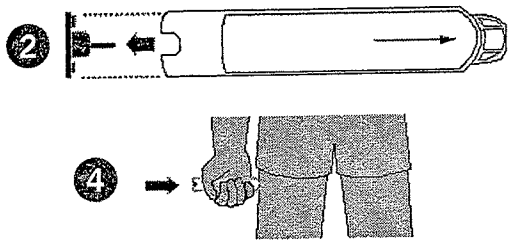
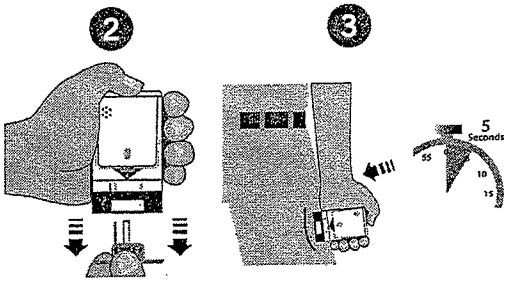
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



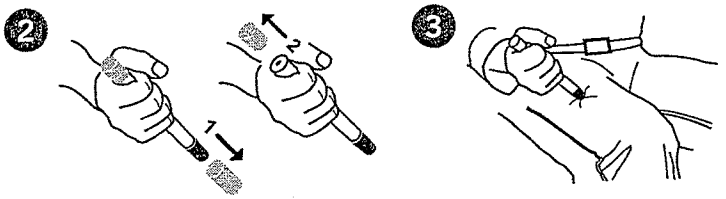
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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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ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade _____

☐ School E-mail _____ ☐ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ☐ Office Phone (___) _____

☐ Office E-mail _____ ☐ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

MONITORING	TREATMENT
RED **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • <u>Call 911 NOW if:</u> 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ☐ 2 ☐ 3 days, if symptoms remain improved • If symptoms are not gone after ☐ 2 ☐ 3 days, move to the **RED ZONE**
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ☐ Recess ☐ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

☐ Administer medications as instructed above

☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student <u>can carry and use his/her inhaler at school</u>

☐ Student needs supervision or assistance to use his/her inhaler medication

☐ Student should <u>NOT</u> carry his/her inhaler while at school ☐ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**