FARE 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.**

⇩ ⇩ ⇩

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

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

In compliance with state regulations, P.L. 2007, C.57 (N.J.S.A. 18A:40-12.3-12.6) Glen Rock Public School staff members have been trained in the administration of epinephrine in the event the nurse is not available and your child experiences an allergic reaction and is unable to self-administer during school activities. Emergency 911 will be called and parents notified if Epinephrine is administered. Please indicate your preference below:

I give permission for the Glen Rock Public School trained staff members to administer epinephrine via auto injector in the event my child has an allergic reaction as documented by his/her medical provider's orders. I acknowledge that the Board, its agents and employees shall incur no liability as a result of any injury arising from the administration of the epinephrine. I hereby agree to indemnify and hold the Board, its agents and employees, harmless from any and all claims, liability, damages and expenses, including reasonable attorneys' fees arising out of, resulting from or in connection with the administration of medication to my child.

Parent / Guardian signature _____ Date _____

_____ I do NOT agree to the above delegation and wish 911 to be called and EPINEPHRINE NOT ADMINISTERED.

Parent / Guardian signature _____ Date _____

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	**OTHER EMERGENCY CONTACTS**
RESCUE SQUAD: _____	NAME/RELATIONSHIP: _____
DOCTOR: _____ PHONE: _____	PHONE: _____
PARENT/GUARDIAN: _____ PHONE: _____	NAME/RELATIONSHIP: _____
	PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE