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

Name: _____ D.O.B.: _____

Allergic 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 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): _____

_____

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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

RAMAPO INDIAN HILLS REGIONAL HIGH SCHOOL DISTRICT
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Parents/guardians

- **It is the responsibility of the parent/guardian to provide a current pre-filled, single dose auto injector mechanism containing epinephrine; prescribed and labeled for your child**
- **The parent/guardian is responsible for replacing the prefilled, single dose auto injector mechanism containing epinephrine when it has expired and /or has been used**
- **Orders must be renewed yearly and provided to the school on or prior to the first day of classes**

Select one-

1. I verify that my child_____has a potenitally life threatening illness and is **unable to self-administer** the prescribed medication in a life threateing situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to the my child. I further acknowledge that the Ramapo/indian Hills School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and Ramapo/Indian Hills School District are followed, I shall indemnify and hold harmless the Ramapo/Indian Hills School District and it's employees or agents against any claims arising out of administration of medication to my child.

_____Date_____

Signature of Parent/Guardian

2. I verify that my child_____has a potentially life threatening illness and has been instructed in self administration of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self-administer** prescribed medication. I further acknowledge that the Rampo/Indian Hills School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by NJ law and Ramapo/Indian Hills policy are followed, I shall indemnify and hold harmless the Ramapo/Indian Hills School District and it's employees or agents against any claims arising out of self-administration of medication by my child.

_____Date_____

Signature of Parent/Guardian