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

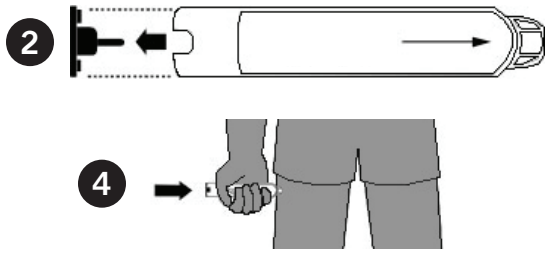
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

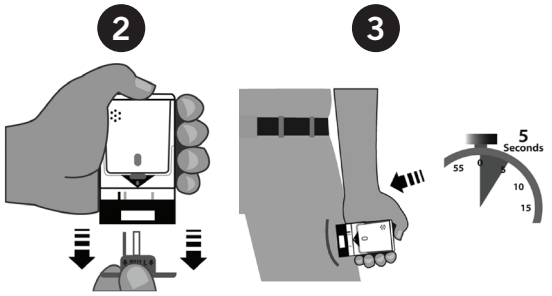
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 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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Medical Plan of Care for School Food Service
(Students with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name	Date of Birth	M F
Name of School/Center/Program	Grade Level/Classroom	
Parent's/Guardian's Name	Address, City, State, Zip Code	
( ) Home Phone	( ) Work Phone	

Part 2: Request for milk substitution for non-disabling special dietary needs only

☐ School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.

☐ School/school district provides _____ as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes ☐ No ☐
List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

Medical Authority or Parent/Guardian Signature:_____ Date:_____

Part 3: To be completed by Physician/Medical Authority

Disability/Special Dietary Needs

Does the child have a **disability**? Yes ☐ No ☐
If Yes,
Please describe the major life activities affected by the disability.

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐
(*These accommodations are optional for schools to make)

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: To be completed by Physician/Medical Authority

Diet Order

List any dietary restrictions, such as food allergies, intolerances or restrictions:

List specific foods to be substituted (Substitution cannot be made unless section is completed):
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up/chopped into bite sized pieces: Finely Ground: Pureed:
List any special equipment or utensils needed:
Indicate any other comments about the child's eating or feeding patterns:

Physician's Name and Office Phone Number		Office Stamp
Physician/Medical Authority's Signature		Date
Part 5: Parent Signature		Date
Part 6: School Nutrition Program Signature		Date

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____
(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ____ Date _____ ____ Date _____ ____ Date_____

____ Date_____ ____ Date _____ ____ Date _____ ____ Date _____ ____ Date_____

A copy of this form should be kept by the School Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.

Emergency Care Plan

Insert Student's Picture

Name: _____ DOB: _____

School: _____ Grade: _____

KNOWN ALLERGIES: _____

_____

COMMON SIGNS OF AN ALLERGIC REACTION (This is not an exclusive list of symptoms)

MOUTH	Itching, tingling, swelling of the lips, tongue, or mouth
THROAT	Itching and/or a sense of tightness in the throat, hoarseness, hacking cough
SKIN	Hives, itchy rash, swelling about the face or extremities
GI	Nausea, vomiting, abdominal cramps, diarrhea
LUNGS	Shortness of breath, repetitive coughing, wheezing
HEART	"Thready" pulse, dizziness or fainting

DURING AN ALLERGIC REACTION, HIS/HER TYPICAL SYMPTOMS ARE:

_____

_____

NOTE: Different symptoms may occur with any reaction and severity of symptoms can change rapidly. A high level of suspicion needs to be maintained for any symptoms exhibited by a student with food allergies. **ACT QUICKLY!!**

IF INGESTION IS SUSPECTED AND/OR SYMPTOMS ARE PRESENT, **IMMEDIATELY** DO THE FOLLOWING:

1. TREATMENT

_____

_____

_____

2. CALL 911 & CERTIFIED SCHOOL NURSE
3. CONTACT PARENT/GUARDIAN/DESIGNEE

Parent/Guardian Emergency Contact: _____

Telephone (h) :_____(w):_____(cell):_____

Parent/Guardian Emergency Contact: _____

Telephone (h) :_____(w):_____(cell):_____

Emergency Contact (if Parent/Guardian not available)/Relationship/Telephone Number:

_____-_____

Healthcare Provider/Telephone: _____

Certified School Nurse Signature:_____ Date:_____