Individualized Health Care Plan for Life-Threatening Allergies Including Food Allergies

To be completed by the student or parent if the child is too young:

Students Name_____ Grade_____

I have allergy/s to _____. I know I need to avoid _____.

The reaction/s I have are: _____

_____

_____

I know my care is _____

_____

_____

The medication I need is _____

How is the medication given? _____

The medication located (where) _____. The back up location for my medication is _____.

I do have/do not have permission to carry my medication. _____

I will carry the medication (where) _____. The back up location for my medication is _____.

I will tell the responsible adult immediately if I have come in contact will the allergen or I am having a reaction.

Student signature_____ Date_____

To be completed by the Parent

_____ (Student's Name) has severe allergies to _____. This allergy may cause _____ in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child of about his/her allergy, how to avoid exposure to the allergen, care to take if exposure occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request treatment of the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of epinephrine. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature_____ Date_____

To be completed by the school

____ Instruction has been given on the medication order and the parent's instruction of care.

____ The students' responsible adults are instructed in the allergy, symptoms, and avoidance, care, and treatment.

____ Epinephrine auto injected device locations are known.

____ If the EpiPen is used, 911 with advance life support will be called.

Principal _____ School Nurse or Health Consultant_____

Teacher_____ PE _____ _____

(If appropriate) Before & After Program Coordinator _____

Coach _____ Date_____

Physician _____ Date _____

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): _____

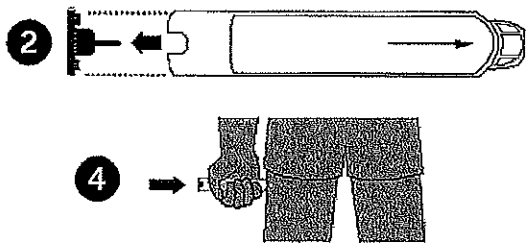
_____

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

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

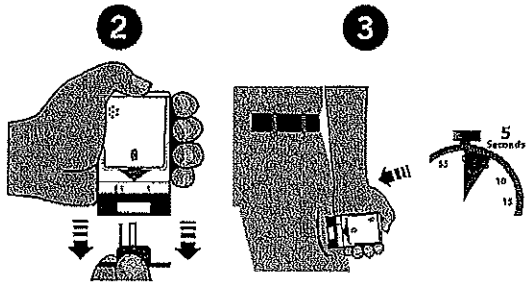
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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".
   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

Medication Permission Form for Life-Threatening Allergies

ALLERGY TO: _____

Student's
Name: _____ D.O.B. _____ Teacher _____

Asthmatic: _____**Yes*** _____ **No** ***High risk for severe reaction**

THIS CHILD'S SIGNS OF AN ALLERGIC REACTION

Systems	**Symptoms**
·**MOUTH***	itching & swelling of the lips, tongue, or mouth
·**THROAT**	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
·**SKIN**	hives, itchy rash, and/or swelling about the face or extremities
·**GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
·**LUNG***	shortness of breath, repetitive coughing, and/or wheezing
·**HEART***	"thread" pulse, "passing-out"

The severity of symptoms can quickly change. * All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

If only symptom(s) are: _____, give _____
medications/dose/route

_____

Then call:
1. Mother _____, Father _____, or emergency contacts.

2. Dr. _____ at _____

This child may/ may not carry this medication. Name where; school, sports events, out of school activities.
If condition does not improve within 10 OR ___minutes follow the steps for "Action for Major Reaction" below:

ACTION FOR MAJOR REACTION
If ingestion is suspected and/or symptom(s) are: _____ give

_____ **IMMEDIATELY!**
Medications/dose/route
Then call:
1. 911 (ask for advanced life support)

2. Mother _____, Father _____, or emergency contacts.

3. Dr. _____ at _____
This child may/may not carry this medication. Name where; school, sports events, out of school address activities.

DO NOT HESITATE TO CALL 911!

_____ _____ _____ _____
Physician's Signature **Date** **Parent's signature** **Date**

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1.	1. _____ Room _____
Relation: _____ Phone: _____	
2.	2. _____ Room _____
Relation: Phone: _____	
3. _____	3. _____ Room _____
Relation: _____ Phone: _____	

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off blue safety cap

2. Place orange tip on outer thigh (always apply to thigh)

3. Swing and firmly push the orange tip for 10 seconds against the mid outer thigh, The EpiPen® unit should then be removed and discarded.

_____ (Student's Name) has severe allergies to _____. This allergy may cause _____ in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child about his/her allergy, how to avoid exposure to the allergen, care to take if exposed occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

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Parent Signature _____ Date_____
"Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute Teachers, and Staff.