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

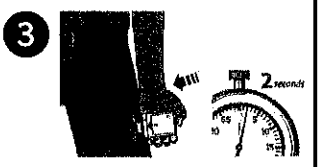
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

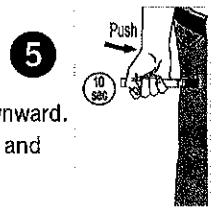


HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

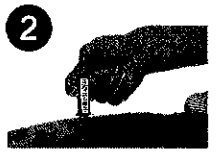


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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 worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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

ROSEHILL CHRISTIAN SCHOOL

ALLERGY ACTION PLAN

STUDENT NAME: _____
(Please Print Legibly)

Parent / Guardian to sign one of two choices:

DESIGNEES OF ADMINISTRATION: This is to verify that the designees of RCS Administration who have been properly trained in the administration of the medication for anaphylaxis have my permission to administer said mediation to my child in the absence of a R.N. Only epinephrine by an auto injector may be given by the delegate / designee.

DATE: _____ Parent / Guardian Signature: _____

I choose NOT to have a designee administer my child's prescribed epinephrine via a pre-filled auto injection in the event of an allergic reaction. I am aware this waiver shall not prohibit self administration (if provided in the section below) or administration by an R.N. I have also received, reviewed and signed the Refusal of Epinephrine Delegate Form.

DATE: _____ Parent / Guardian Signature: _____

WAIVER OF LIABILITY (Waiver must be signed by parent / guardian in order for administration of medication by nurse, school designee or self administration by pupil).

I understand that this request is effective for the school year in which it is granted and must be renewed each subsequent school year. I acknowledge that the school and its agents shall incur no liability as a result of injury arising from self administration, delegate and /or nurse administration of medication as prescribed to my child and I hold harmless Rosehill Christian School and its employees or agents against any claims. For the child who may self administer, I acknowledge that I may be liable if any other child is injured by the inadvertent use of this medication and recognize that my child will be responsible for having the medication in his / her possession during school and school sponsored events.

DATE: _____ Parent / Guardian Signature: _____

PHYSICIAN REQUEST FOR SELF ADMINISTRATION (if applicable):

As primary health care provider of the above-named student, I certify that the student has been instructed in the proper method of self administration and certify that the child is capable of self administration and has demonstrated this to my satisfaction.

Name of Medication(s): _____

DATE: _____ Physician Signature (MD/NP): _____

Physician Stamp: Physician's Name (Print Legibly): _____

ROSEHILL CHRISTIAN SCHOOL

2023-2024

REQUEST TO DISPENSE PRESCRIPTION MEDICATION

To Be Completed by the Physician:

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by Administration or its designee.

1. Name of Student: _____ Date of Request: _____

2. Address of Student: _____ Zip Code: _____

3. Medication(s) to be administered (per prescription label):

   a. _____ Purpose: _____

   b. _____ Purpose: _____

   c. _____ Purpose: _____

4. Possible reaction that, if they occur, should be reported to the physician:

   a. _____

   b. _____

5. Any special instructions (e.g. storage): _____

6. Medication to be continued as above until: **Begin Date:** _____ **Discontinued Date:** _____

7. Physician's Signature: _____

   Address: _____

   Phone Number: _____ Emergency Number: _____

To Be Completed by the Parent / Guardian:

I (we) request that medication be administered to our child: in accordance with the above instructions of our physician, Dr. _____

I (we) understand that the administration of said medication is to be dispensed under the supervision of either a member of Administration or their designee.

I (we) understand that the medication is to be delivered to the school by the parent/guardian only and unused medication will be returned to the parent/guardian only. Medication not picked up by the parent/guardian within 3 days of notification will be disposed of by Administration or their designee.

I (we) agree to deliver a school month's supply of medication to the school in the original container the first school day of each month unless other arrangements are made with Administration. We understand that the empty container will be returned home the last school day of each month with the students.

I (we) agree to notify the school immediately if:

1. We change physicians.
2. The medication or dose is changed.
3. The administration of the medication is to be terminated.

Signature/Date: _____ Daytime Phone: _____

Signature/Date: _____ Daytime Phone: _____

Authorized Person Receiving Medication: _____ Date/Time: _____

ROSEHILL CHRISTIAN SCHOOL

HOLD HARMLESS AGREEMENT_Allergies
2023-2024

_____ I / We acknowledge that despite good faith efforts by Rosehill Christian School, our child may encounter allergens or other environmental agents in the School premise, due to the nature of the School environment and exposure to other children.

_____ FOOD ALLERGIES: I / We understand that if my / our child suffers from food allergies, I / We must provide a daily snack for my / our child. I understand that Rosehill Christian School is not responsible for the monitoring of the allergen content or diabetic content of the snacks I / we provide. If I / we fail to provide a daily snack for my / our child, the School may at its sole discretion provide my / our child with a daily snack. I / we acknowledge that we have been advised of our responsibility to provide a daily snack for my / our child, and I / we waive the right to any suit or complaint against Rosehill Christian School and/or any employee, teacher, or agent of the school arising out of the discretionary provision of a snack to my / our child.

_____ INSECT ALLERGIES: I / We understand that if my / our child suffers from insect allergies that I must provide specific direction relative to participation in outdoor activities. I / We understand that Rosehill Christian School is not responsible for monitoring insect interaction with children in its care. I / We further understand that exposure to insects may occur at any time in any location and waive the right to any suit or complaint against Rosehill Christian School and/or any employee, teacher, student, or agent of the school.

_____ ALL ALLERGIES: I / We agree to comply with the individualized Allergy Action Plan. I / We understand that this may include the requirement to travel with and/or attend off campus activities should a designee not be available to administer treatment should there be a reaction. I / We recognize that the lead teacher/coach is unable to be the medical designee as he/she is responsible for supervising the entire group. I / We further understand that if a designee is not available for assignment and I / we are unable to travel with and/or attend the off campus event, it is my / our responsibility to designate an adult to go in my / our place. In the event there is no designee available, I / we understand that my / our child may not participate in the school activity. If applicable, school administration will review the circumstances to determine if the absence will be considered excused or unexcused.

_____ ALL ALLERGIES: Recognizing and understanding the potential risks of allergen exposure, I / we are choosing to enroll my / our child in Rosehill Christian School. I understand that by signing this release of liability, assumption of risk, hold harmless, agreement to indemnify and not to sue, is legally binding on me / us, Minor, respective heirs, personal representatives, relatives and assigns and that I / we am giving up both my / our and minor's legal rights and remedies which otherwise would be available to me / us and my / our Minor, heirs, personal representatives, relatives or assigns against Rosehill Christian School.

I am of legal age and voluntarily sign this release of liability, assumption of risk, hold harmless, agreement to indemnify and not to sue.

Relationship to Student (initial one): _____ Parent _____ Legal Guardian

_____ _____

Parent / Guardian Signature Date

_____ _____

Administrator Signature Date