**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: ___________________________ Date of Birth: ___________________________

Allergic to: ___________________________

Weight: __________________ lbs. Asthma: □ Yes (higher risk for a severe reaction) □ No

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
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: ________________
### Medication Administration Permission Form

**Student Name:** ____________________________  **Date of Birth:** __________  **Student ID#:** __________

**Medication and food allergies:** __________________________________________________________

**Other medications taken at home:** _______________________________________________________

**Today’s Date:** ______________  **This medication form is valid for the current school year.**

**Students in grades KG-12 ARE NOT ALLOWED** to carry or self-administer prescription or over-the-counter medications except as allowed by law for diabetes, asthma and anaphylaxis

**Austin ISD Health Services and Nursing require the following:**

- **Only those medications that are medically necessary during school hours for a student’s attendance or written in an IEP should be sent to school.**

- A U.S. medical practitioner’s written order/parent or guardian consent dated for the CURRENT school year and signed by the parent, legal guardian or other person(s) having legal authority of the student **AND** the medical practitioners who is licensed to practice medicine in the United States/State of Texas.

- Medication in the original, properly labeled container from a registered pharmacist (name of the student, name of the medicine with strength, dosage and directions; route to be given, name of prescribing physician who is licensed in Texas, and current date.

- Non-prescription and over-the-counter medications require the above (AISD Student Handbook, FFAC local)

- **Students ARE NOT ALLOWED** to carry any medication prescribed or over the counter, or to self-administer the medication unless ordered by the U.S. licensed medical practitioner. By law the only medications with a medical order/permission that may be carried by a student is an asthma inhaler, EpiPen, and/or insulin/diabetes.

**Special medication instructions:** _______________________________________________________

**All unclaimed medication will be disposed of on the last day of school as required by law.**

- I request authorized Austin ISD to administer the medication(s) listed on this form to my child during school hours to include field trips according to medication label and/or physician instructions. **Any changes in medication and/or dosage require a new physician's order and signature.**

- I release school staff from liability in the event of ill effects that may occur with administration of a medication.

- I agree to abide by federal and state law and Austin ISD guidelines for medications in the school setting.

- I understand that the school nurse may designate trained Austin ISD staff to administer medication(s).

### MEDICATION ADMINISTRATION INSTRUCTIONS

<table>
<thead>
<tr>
<th>Medication Name and Expiration Date (Month/Year)</th>
<th>Dosage</th>
<th>Time(s) to Give Medication at School</th>
<th>How Medication is Taken (by mouth, eye, ear nose, tube, inhaler, with a topical cream or injection)</th>
<th>Condition for Which Medication is Given</th>
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**Parent/guardian signature** ____________________________  **Parent/guardian name (print)** ____________________________  **Date** __________

**Physician signature** ____________________________  **Physician name (print or stamp)** ____________________________  **Date** __________

Rev. 5/23
# Request for Dietary Accommodation

Please complete this form and provide a copy to the school cafeteria. The Parent/Legal Guardian and School Nurse will be notified after the request is evaluated by the Dietitian.

## PART A. THIS SECTION TO BE COMPLETED BY A PARENT / LEGAL GUARDIAN

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Age:</th>
<th>Student ID:</th>
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</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Classroom:</td>
</tr>
<tr>
<td>Printed Parent or Guardian’s Name:</td>
<td>E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## PART B. THIS SECTION TO BE COMPLETED BY A MEDICAL AUTHORITY LICENSED BY THE STATE OF TEXAS TO WRITE MEDICAL PRESCRIPTIONS

Medical authority licensed by the state of Texas to write medical prescriptions is required to complete PART B and sign.

1. **Does the Child have a disability recognized by the American’s with Disability Act (ADA)?**
   - [ ] YES  [ ] NO  If NO, skip to Question #3

2. **If YES, please identify the disability and describe the major life activities affected by the disability.**

3. **If the Child does not have a disability, does the child have a food allergy or intolerance that results in an anaphylactic reaction when exposed to the food (s) to which they have problems?**
   - [ ] YES  [ ] NO

4. **If the answer to Questions 1 or 3 is YES, please check the following that affect the child.**
   - [ ] Dairy
   - [ ] Eggs
   - [ ] Fluid Milk
   - [ ] Cheese
   - [ ] Yogurt
   - [ ] Whole Eggs (such as scrambled or boiled eggs)
   - [ ] Menu items with any dairy ingredients
   - [ ] Menu items with any egg listed as ingredient
   - [ ] Gluten
   - [ ] Wheat
   - [ ] Peanut
   - [ ] Tree Nut(s)
   - [ ] Soy Protein
   - [ ] Sesame
   - [ ] Fish
   - [ ] Shellfish
   - [ ] Other: ________________________________

Any additional information:

5. **For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate “all”:**
   - (a) Cut up or chopped into bite size pieces. ________________________________
   - (b) Finely ground. ________________________________
   - (c) Pureed or Blended. ________________________________

6. **Indicate any other comments about the child’s eating or feeding patterns.**

_______________________________________________________________

PART C. THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

<table>
<thead>
<tr>
<th>School Nurse:</th>
<th>Phone:</th>
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7. **Does the Child have “Individualized Health Care Plan” (IHCP)?**  [ ] YES  [ ] NO

8. **Does the Child have a 504 Plan?**  [ ] YES  [ ] NO