

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
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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): _____



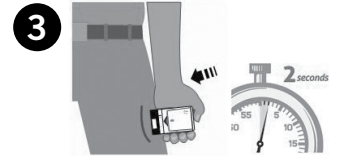
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

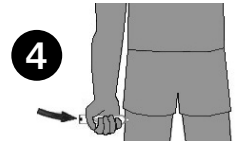
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



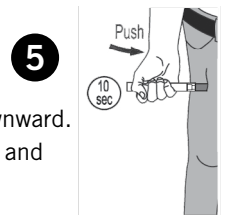
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 ADRENALICK®), 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.

MEDICATION ADMINISTRATION INSTRUCTIONS				
Medication Name and Expiration Date (Month/Year)	Dosage	Time(s) to Give Medication at School	How Medication is Taken (by mouth, eye, ear nose, tube, inhaler, with a topical cream or injection)	Condition for Which Medication is Given

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).



 Parent/guardian signature Parent/guardian name (print) Date


 Physician signature Physician name (print or stamp) Date



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

Student's Name:		Age:	Student ID:
School:	Grade:	Classroom:	
Printed Parent or Guardian's Name:		E-mail:	
		Phone:	

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 Fluid Milk Cheese Yogurt Eggs 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.

_____ Office Phone: _____ Office Fax: _____
Medical authority's printed or stamped name

_____ Date
Medical authority's signature

PART C. THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

School Nurse: _____ Phone: _____

7. Does the Child have "Individualized Health Care Plan" (IHCP)? ___ YES ___ NO

8. Does the Child have a 504 Plan? ___ YES ___ NO