



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.

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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
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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: _____

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

ST. LUKE'S SCHOOL ALLERGY INDIVIDUAL HEALTH CARE PLAN (IHCP)

Name: _____ DOB: _____ Allergy to: _____

Level of Allergy: (Circle) Inhalation Tactile Ingestion Unknown Age of Onset: _____

Describe symptom(s) of allergic reaction(s): _____

History of Anaphylaxis: (Circle one) Yes No Treatment: EpiPen Benadryl Other: (please specify) _____

Other health conditions/medications (e.g., Asthma): _____

Location of Epinephrine at school: Health Office (unlocked cabinet during regular school hours)

Preventive Measures

- Parent/guardian will inform bus company personnel of their child's allergy medication requirements, & emergency contact information. Parent/Guardian Initials _____
- **Medications that are kept in the nurse's office are available during school hours only.** For any before and after school activities (*Including C.A.M.P.*), it is the parent/guardian responsibility to inform activity coordinator of their child's allergy, treatments & provide emergency medications.
Parent/Guardian Initials _____
- School personnel who may be involved in the care of a student who has been diagnosed with an allergy, will be informed of the EHCP and IHCP.
- The student will be accompanied to the health office in the event of an allergic reaction.
- Trained school personnel will carry the prescribed emergency medication(s), and a copy of the EHCP on the field trip and accompany student at all times if the parent is not present. NOTE: Student may self-carry with doctor orders.
- Other Provisions required:

EMERGENCY CONTACTS (please print) Treat student before calling Emergency Contacts. - CALL 911

Parent/Guardian: _____ Phone: (____) ____ - ____

Parent/Guardian: _____ Phone: (____) ____ - ____

Other: Name/Relationship: _____ Phone: (____) ____ - ____

Parent/Guardian Authorization Signature Date

Certified School Nurse Teacher Authorization Signature Date