OAK HALL SCHOOL
SCHOLARSHIP · LEADERSHIP · SERVICE

Dear Parent/Guardian:

In order to provide better care to our students with allergies and medical conditions, we need your assistance in providing specific information with an Action Plan in case your child develops an allergic reaction. This Action Plan will help us to act quickly while we contact you. This Plan can also be requested from your pediatrician.

ACTION PLAN

Attach Child's photo

Will be active for the school year (current): _____

1. STUDENTS NAME: _____
2. AGE _____ 3. DATE OF BIRTH _____
4. ALLERGY _____
5. REACTION _____
6. INTERVENTION: *(Example: call 911, give Benadryl [indicate dose], call parents)*
   a. 1st action: _____
   b. 2nd action: _____
   c. 3rd action: _____
7. Provide emergency names and phone numbers:

	Name	*Phone Number (include a/c)*
a. 1st call:	_____	_____
b. 2nd call:	_____	_____

8. Physician's name and phone number: *(please print)*
   Name: _____ Phone: (____)_____
9. Signature of Parent/Guardian:
   Print Name_____ Date: _____
   Signature: _____

If you have any questions or concerns, please do not hesitate to give us a call at (352) 332-3609.

Oak Hall School

Recv. _____ Admin. + _____ 08/18

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 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: ☐ 0.15 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

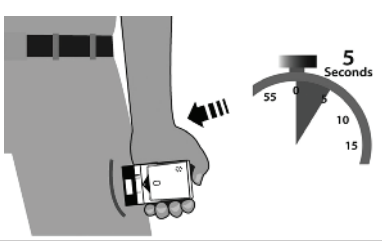
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

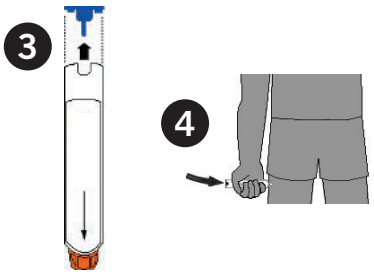
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



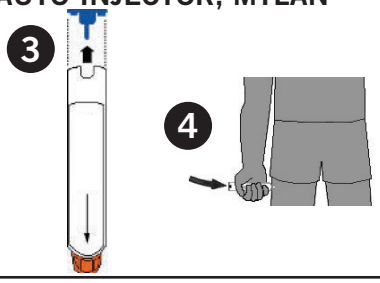
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



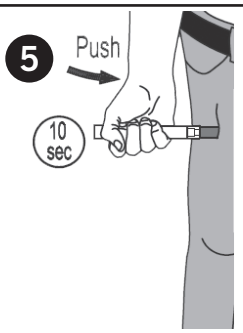
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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



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

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



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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

OAK HALL SCHOOL
SCHOLARSHIP · LEADERSHIP · SERVICE

REQUEST AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

EPI PEN

Name of Student: _____ Grade: _____

Address: _____ Date: _____

_____ DOB: _____

_____

Condition for which the medication is needed to be administered during school hours:

_____

Drug: __EPI PEN___ Type: _____

Dosage of Epi-Pen: _____

Method of Administration: _____

Time to be administered: _____

□ Medication will be administered from _____ to _____ (end date)

Relevant side effects to be observed (if any): _____

_____

If there are side effects, plan for management: _____

_____

Authorization by Parent/Legal Guardian of the above medication by school personnel:

I request that the above medication, ordered by the named prescriber for my child, _____, be administered by School Personnel. I understand that I must supply the school with the prescribed medication in the original container and properly labeled by a physician or pharmacist. I understand that any medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the school year.

Signature: _____ Date: _____

Name *(printed)*: _____ Relationship to student: _____

Phone number(s): Home: _____ Cell: _____ Work: _____

OAK HALL SCHOOL
SCHOLARSHIP · LEADERSHIP · SERVICE

REQUEST AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

OTHER MEDICATION

Name of Student: _____ Grade: _____

Address: _____ Date: _____

_____ DOB: _____

_____

Condition for which the medication is needed to be administered during school hours:

_____

Name of Medication *(as appears on bottle)*:_____

Dosage of medication to administer:_____

Method of Administration: _____

Time to be administered: _____

□ Medication will be administered from _____ to _____ (end date)

Relevant side effects to be observed (if any): _____

_____

If there are side effects, plan for management: _____

_____

Authorization by Parent/Legal Guardian of the above medication by school personnel:

I request that the above medication, ordered by the named prescriber for my child, _____, be administered by School Personnel. I understand that I must supply the school with the prescribed medication in the original container and properly labeled by a physician or pharmacist. I understand that any medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the school year.

Signature: _____ Date: _____

Name *(printed)*: _____ Relationship to student: _____

Phone number(s): Home: _____ Cell: _____ Work: _____