Fulton Science Academy 2019-2020

ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ Grade: _____ D.O.B.: _____

Allergy to: _____ Homeroom Teacher: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

Please attach your child's picture here

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____ Date of Last Episode: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, or came in contact with, and HAS symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, or came in contact with, even if symptoms are not 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. (Parent Please Supply)
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: _____

(Parent-Please supply melting, chewable, or liquid)

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

Ask pharmacist to supply extra labels for EACH device that you carry, for school, and for home.

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

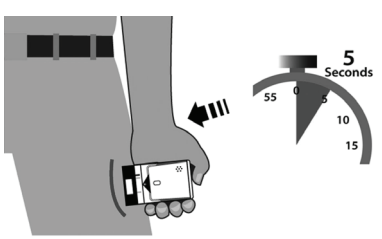
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

How to use each device

ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

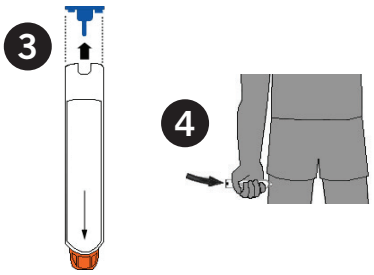
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



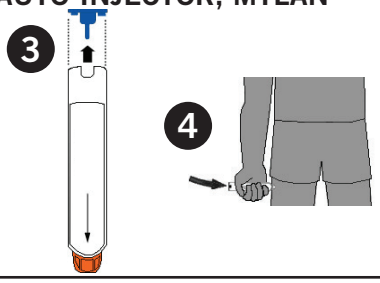
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.



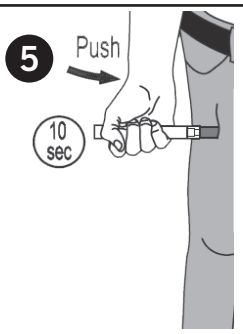
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20_19__ - 20_20__

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Fulton Science Academy and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that: All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

- **Medications must be in the original container.**
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Fulton Science Academy care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT _____ **BIRTHDATE**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION Epinephrine Brand _____ **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

To be completed by Physician for long-term medications (more than two weeks):"Physician" as defined in Article 2 of the Medical Practice Act of Georgia ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20 *19* - 20 *20*

ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Fulton Science Academy and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that: All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

- **Medications must be in the original container.**
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Fulton Science Academy care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT _____ **BIRTHDATE**_____ **GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION Antihistamine Brand _____ **Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____ **PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE**_____
PHONE _____

To be completed by Physician for long-term medications (more than two weeks):"Physician" as defined in Article 2 of the Medical Practice Act of Georgia ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____ **DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____

AUTHERIZATION FOR STUDENTS TO CARRY A PRESCRIPTION LABELED INHALER, EPINEPHARINE AUTO INJECTOR, INSULIN, GLUCAGON, DIABETIC SUPPLIES, EMERGENCY SEIZURE MEDICATION, OR OTHER APPROVED MEDICATION.

20_***19***_ - 20_***20***_

EACH MEDICATION WILL REQUIRE A PRESCRIPTION LABEL ATTACHED TO THE ACTUAL MEDICATION

_____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or_____ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home. **ASK your pharmacist to make separate prescription labels for each device, for school, for home, and for the one you are carrying.

Name of Medication: _____

_____ _____

Physician's Name *Date*

_____ _____

Physician's Address *Phone*

_____ _____

Physician's Signature *Date*

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the School Nurse each time I take my medication.

_____ _____

Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Fulton Science Academy and its employees of any legal responsibility when the above-named student administers his/her own medication.

_____ _____

Parent/Guardian Signature *Date*