LIFE SCHOOL

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Please fill out this form if your child has an allergy, including food allergies. This form must be signed by a physician.

Name: _____ D.O.B.: _____

Allergic to: _____

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

History of anaphylaxis: ☐ **Yes** ☐ **No**

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

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. **ADMINISTER 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.

ADDITIONAL PHYSICIAN COMMENTS

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 AND **CALL 911**.

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 and call 911.

☐ **If this box is checked by the child's physician, the child has an extremely severe allergy to** _____ **and should be given epinephrine at the first sign of any symptoms, even if mild.**

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM ☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

☐ Patient may self-carry ☐ Patient may self-administer

_____ _____ _____ _____

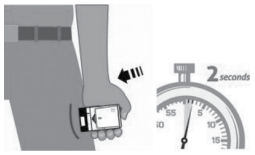
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE **DATE** **PHYSICIAN/HCP AUTHORIZATION SIGNATURE** **DATE**

LIFE SCHOOL

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

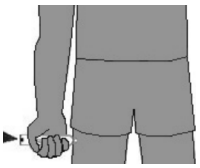
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



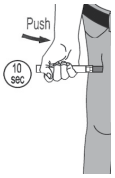
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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.



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.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



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:** _____

LIFE SCHOOL

FOOD AND CHILD NUTRITION SERVICES DIETARY REQUEST

☐ **NEW Request**
☐ **CHANGE or MODIFY Existing Request**
☐ **DISCONTINUE Request**

STUDENT'S NAME (Last, First) *NOMBRE DEL ALUMNO (Apellido, Nombre)*

Date of Birth
Fecha de nacimiento

I understand as a parent, that it is my responsibility to renew this form **any time there is a change or discontinuation of dietary needs** and give to the school nurse. I give Life School permission to speak with the medical authority to discuss dietary needs as ordered. *Como padre, entiendo que es mi responsabilidad renovar este formulario cada vez que haya un cambio o suspensión de las necesidades dietéticas y se lo entregaré a la enfermera de la escuela. Doy permiso a Life School para que hable con la autoridad médica para analizar las necesidades dietéticas según lo ordenado.*

X

PARENT/GUARDIAN SIGNATURE *FIRMA DEL PADRE/TUTOR LEGAL* **DATE** *FECHA*

CONTACT NUMBER OF PARENT/GUARDIAN
NÚMERO DE CONTACTO DEL PADRE O TUTOR LEGAL

Which meals provided by the School Cafeteria will the student eat?
☐ Breakfast ☐ Lunch ☐ NONE

Does the student have an identified disability? (IEP or 504 Plan)?
☐ IEP ☐ 504 ☐ No

Parent/Guardian Email Address (CLEARLY PRINT) *Correo electrónico del padre o tutor legal (ESCRIBA CON CLARIDAD)*

Students with a Medical Disability/Life Threatening

Section A. To be Completed by Physician/Medical Authority
(Debe ser llenada por un médico o autoridad médica)

Does the student have a disability which restricts the student's diet?
☐ Yes* ☐ No

* **If Yes**, describe or state the student's disability or diagnosis. Explain why it restricts the student's diet and list major life activities affected by the disability:

_____
_____
_____
_____

I. Texture Modification: Special Utensils required: _____

☐ Year Round ☐ Temporary: Start: _____ Stop: _____

Liquids:
☐ Thin (Regular liquids)
☐ Nectar thick
☐ Honey Thick
☐ Pudding Thick

Solids:
☐ Mechanical Soft (ground)
☐ Mechanical Soft (chopped)
☐ Pureed (Applesauce texture)

II. Therapeutic Diet Order: (Write specifics in space provided)

☐ Sodium Restriction: _____
☐ Renal: _____
☐ PKU: _____
☐ Cardiac: _____
☐ Diabetic: _____
☐ Other: _____

Students with NO Medical Disability/Non-Life Threatening

Section B. To be Completed by Parent/Guardian *(No Medical Authority Signature Required. May assist parent in completing section).*
Esta sección la tiene que llenar el padre/tutor legal (No necesita la firma de un médico. Puede brindar ayuda al padre para llenar esta sección)

Currently, the Child Nutrition Department does not provide non-dairy or lactose-reduced/lactose-free milk substitutes to non-disabled students who cannot drink fluid milk due to a medical or special dietary need. Additionally, juice is not an approved fluid milk substitute, unless clearly stated by a physician in relation to a student with a life-threatening allergy or disability. Milk is not required to be taken as part of Offer-vs-Serve regulations and students may choose juice when offered as a fruit component in the meal.

Although food substitutions or modifications for students with intolerances and allergies, or religious meal restrictions are included on this form, Life School is not required to provide substitutions to students without disabilities or life-threatening (anaphylaxis) allergies. Such determinations are made on a case-by-case basis.

Lactose Intolerance (Intolerancia a la lactosa)

☐ No Yogurt due to Lactose Intolerance
(No yogur debido a intolerancia a la lactosa)
☐ No Cheese due to Lactose Intolerance
(No queso debido a intolerancia a la lactosa)
☐ No Fluid Dairy Milk due to Lactose Intolerance
(No leche debido a intolerancia a la lactosa)
Substitute with (Sustituir con): ☐ Lactose free milk (Leche sin Lactosa) ☐ Water (Agua)

Religious/Cultural Beliefs Food Restrictions:
(Restricciones alimenticias por creencias religiosas/culturales)

☐ **No Pork (No Cerdo)**
☐ **No Beef (No Res)**
☐ **No Turkey (No Pavo)**
☐ **No Chicken (No Pollo)**
☐ **No Fish (No Pescado)**
☐ **No Shellfish (No Mariscos)**
☐ **No Milk Products (No Productos Lácteos)**
☐ **No Egg Products (No Derivados de Huevos)**

Other (Otro): _____
_____
_____

***To be completed only by STUDENT'S TREATING PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER** I certify that the above named student needs to be offered food substitutions as described above. Life School will attempt to accommodate substitutions but reserves the right to modify the menu based on product availability.*

Printed Name of Medical Authority _____ ☐ **MD** ☐ **DO** ☐ **PA-C** ☐ **NP** ☐ **RD/RDN** **DATE** _____

Signature of Medical Authority _____ **CONTACT TELEPHONE NUMBER** _____

School Nurse - PLEASE COMPLETE

Printed Name of RN, Email & Phone # _____ School _____

Printed Name of School Café Supervisor, Email & Phone # _____

Scan and Email form to: _____

CONTACT _____ **WITH QUESTIONS OR CONCERNS**