

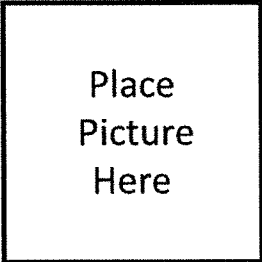
Flemington-Raritan Regional School District

Anaphylaxis/Significant Allergic Reaction Action Plan

Name: _____ D.O.B. _____

Allergy 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.








1A. Extremely reactive to the following: _____ . THEREFORE:

[] If checked, give epinephrine immediately for ANY symptoms if ingestion/sting/exposure was likely.

[] If checked, give epinephrine immediately if ingestion/sting/exposure definitely occurred.

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	<p>OR A COMBINATION of symptoms from different body areas.</p>





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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 don't 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 SYMPTOM 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

Delegate for Epinephrine permitted: [] Yes [] No

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

This is a modification of the Food Allergy and Anaphylaxis Action Plan provided by F.A.R.E.

OVER

Flemington-Raritan Regional School District Anaphylaxis/Significant Allergic Reaction Action Plan

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To be completed by Healthcare Provider (Continued from Page 1)

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See attached instructions for auto-injection technique.

1B. Permission to Self-Administer Medication (check all that apply):

- This student is capable and has been instructed in the proper method of self-administering emergency epinephrine.
- This student may self-administer one unit dose of the prescribed antihistamine.
- This student is not approved to self-medicate.

1C. Additional Information

Has allergy testing been recommended? ___ Yes ___ No Completed? ___ Yes ___ No

If venom reaction, has allergy desensitization been recommended? ___ Yes ___ No Completed? ___ Yes ___ No

Does student require seating at an allergen free cafeteria table? ___ Yes ___ No ___ Parent/School decision

Physician/Healthcare Provider Signature

Date

Healthcare Provider Name, Address, Phone

(Printed or Stamped)

END OF HEALTHCARE PROVIDER SECTION

Location of Epinephrine

Health Office _____ Main Office _____ Self-Carry _____ Other _____

SECTION 3 – TO BE COMPLETED BY PARENT

A. Parent Authorization (to be completed for all students)

I hereby give permission for my child to receive medication at school as prescribed above. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff who need to be informed to assure student safety and who have been instructed on maintaining student confidentiality.

Date _____ Parent Signature _____

B. Parent authorization for the administration of epinephrine by designees/delegates (to be completed for all students for whom the healthcare provider has completed Step 1B for epinephrine delegates and parent gives consent to trained delegates for their child.)

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the district delegates/designees trained by the certified school nurse to administer epinephrine in the event the school nurse is not present at the scene. I understand that the district and its employees shall have no liability as a result of any injury arising from the administration of epinephrine to my child and that the parents and guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine to a student via a pre-filled auto-injector mechanism

Date _____ Parent Signature _____

C. Parent Authorization for students with physician permission to self-administer medication

1. I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration by the student of the medication prescribed on this form and that I indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

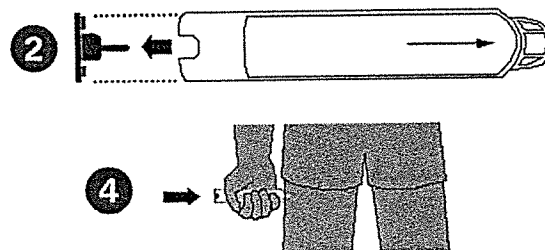
Date _____ Parent Signature _____

2. I give permission for my child to self-administer medication as prescribed on this form for the current school year as I consider him/her to be responsible and capable of self-administration of medication. Medication must be kept in its original prescription container. I understand my child is to keep the medication for self-administration with him/her at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a single pre-measured dose of antihistamine, in its original labeled container, is to be kept with the student , along with the epinephrine, at all times. Extra medication will be sent to school to be kept in the Health Office in case my child forgets to bring the medication prescribed.

Date _____ Parent Signature _____

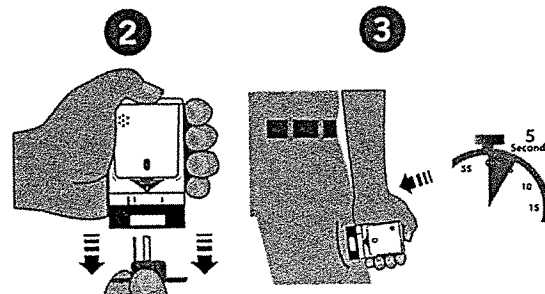
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



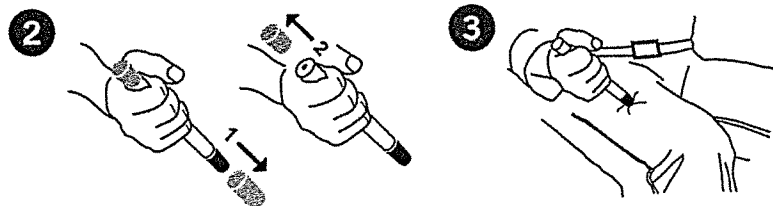
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE