Requirements for Developing a Individualized Health Care Plan for Life-Threatening Allergies

An allergy is a systemic or local reaction to "triggers." The body can respond to triggers with mild symptoms to life-threatening allergic anaphylaxis.

"Requirements for Developing an Individualized Health Care Plans for Life-Threatening Allergies" will cover the responsibility of the parents, school, and student. Follow the steps out lined in "Serious Chronic Illness" for help in developing a health care plan. The "Emergency Allergy Medication Permission Form" and the "Individualized Health Care Plan for Life Threatening Allergies including Food Allergies" can be used.

Parents

- Notify the school of all allergies a student has.
- Educate the student about the allergies.
- Educate the school on the allergen and avoidance of the allergen.
- Provide a written and signed statement form by the physician that includes requirements from the "Medication at School "section and the following:
  a. the student's allergy, signs and symptoms, and instruction for care,
  b. the times at which or circumstances under which the medicine may be administered;
  c. when to call EMS.
- Provide a written statement releasing the school, the Archdiocese and diocesan employees and agents from liability for an injury arising from medication use. Also identifying the school, the school district, its employees and agents from any claim arising from the student's medication use.
- Provide the medication with proper medication label. Replace the medication after use or upon expiring.

School

- The school will take all steps necessary to help a student with allergies avoid the allergen.
- For a student with severe allergies, the parent, student, principal, school nurse or health consultant, teacher, and if appropriate coaches, the before and after program coordinator, and others will develop and sign an individualized health care plan
- All teachers, the principal, nurse or health consultant, and if appropriate coaches and the before and after program workers need to know the student who has serious allergic reactions, the signs and symptoms of a reaction, instruction of care, and proper treatment.
- All teachers, the principal, nurse or health consultant, and if appropriate, coaches and the before and after program workers need to know the students who are on epinephrine treatment. They need to know the specific allergy, the warning signs, where the medication is, and emergency treatment. Any time an Epipen is used 911 will be called and Advanced Life Support will be asked for.
- All teachers, the principal, nurse or health consultant, and if appropriate, coaches and the before and after program workers need to know the location of the epinephrine (Epipen) that is with the student and the location of the back up.

Student

- Every student with an allergy needs to know his/her allergy, how to avoid the allergen, the reaction they have, care they need, restriction, and treatment.
- The student, if ordered, can carry his/her own epinephrine auto-injector device that is labeled appropriately including the expiration date and stating in writing where the student will carry the Epipen. The student will know the back-up location and the location will be stated in writing. The student is to notify an adult immediately if he/she has come in contact with allergen.

Individualized Health Care Plan for Life-Threatening Allergies
Including Food Allergies

To be completed by the student or parent if the child is too young**:**
Students Name_____ Grade_____
I have allergy/s to _____. I know I need to avoid _____.
The reaction/s I have are: _____
_____
_____
I know my care is _____
_____
_____
The medication I need is _____
How is the medication given? _____
The medication located (where) _____. The back up location for my medication is _____.
I do have/do not have permission to carry my medication. _____
I will carry the medication (where) _____. The back up location for my medication is _____.
I will tell the responsible adult immediately if I have come in contact will the allergen or I am having a reaction.
Student signature_____ Date_____

To be completed by the Parent
_____ (Student's Name) has severe allergies to _____. This allergy may cause _____
in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child of about his/her allergy, how to avoid exposure to the allergen, care to take if exposure occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request treatment of the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of epinephrine. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature_____Date_____

To be completed by the school

____ Instruction has been given on the medication order and the parent's instruction of care.
____ The students' responsible adults are instructed in the allergy, symptoms, and avoidance, care, and treatment.
____ Epinephrine auto injected device locations are known.
____ If the EpiPen is used, 911 with advance life support will be called.

Principal _____School Nurse or Health Consultant_____

Teacher_____ PE _____ _____

(If appropriate) Before & After Program Coordinator _____

Coach _____Date_____

Physician _____ Date _____

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.

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

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

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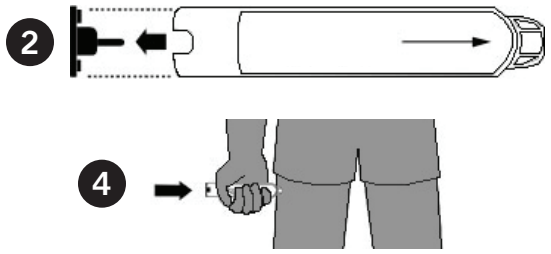
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

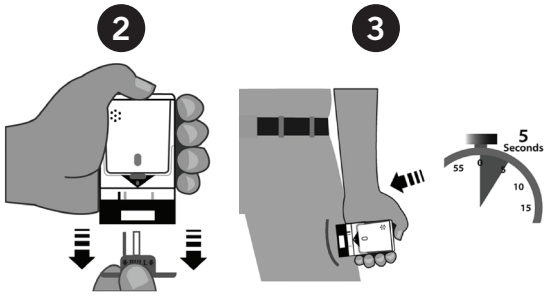
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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