FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic 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:_____

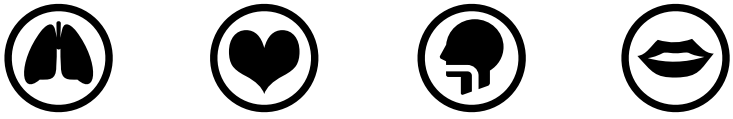
THEREFORE:

☐ 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

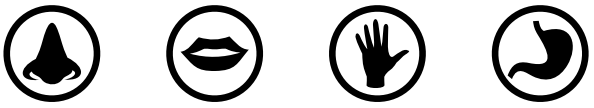
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **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. 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: ☐ 0.1 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

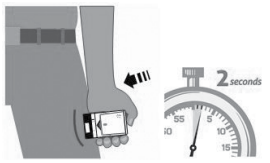
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2025

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

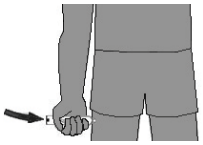
FARE
Food Allergy Research & Education

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



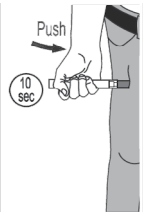
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

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.
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: _____

ROXBURY TOWNSHIP PUBLIC SCHOOLS

Succasunna, NJ

Medication Policy

Effective June 2020, Roxbury Township Board of Education adopted revised Policy #5330 regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
    a. Name of the student
    b. Diagnosis or type of illness involved
    c. Name of the medication
    d. Dosage
    e. Time of administration
    f. Time when its use will be discontinued
    g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled containe**r. Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at www.roxbury.org/Page/749.

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | Medication Administration Daily Log (to be completed for each medication)

v.20231211

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R Franklin Jefferson Kennedy Nixon

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Parent/Guardian's signature granting permission for administration of medication/sharing of information with appropriate staff members:

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

Name & Dosage of Medication _____ Route _____ Time(s) Given in School _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

Reason for medication _____

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Apr																															
May																															
Jun																															

Initial & Signature of Person administering medication Codes^

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

(A) Absent
(O) No Show
(W) Dosage Withheld
(N) No Medication Available
(E) Early Dismissal
(F) Field Trip
(X) No School (e.g. Holiday; Weekend; Snow Day; etc.)

^See reverse side for reporting significant information.

This permission form is effective only for the school year for which it is granted and must be renewed each school year.

Date	Explanation (with Signature)	Date	Explanation (with Signature)

ROXBURY SCHOOL DISTRICT | Permission for Self-Administration of Medication for Potentially Life-Threatening Illness

v.20250613-1015

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Name of Medication _____

Dosage of Medication _____

Guidelines for Administration *(Please be specific)* _____

_____

Possible Side Effects _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

I certify _____ suffers from a potentially life-threatening illness _____
(Student's Name) *(Condition)*

and: ■ is capable of, and has been instructed in, the proper method of self-administration of the above stated medication; ■ is physically fit to attend school and is free of contagious disease; and ■ the medication must be administered during the school day or the student would not be able to attend school.

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

Parent/Guardian's signature granting permission for self-administration of medication/sharing of information with appropriate staff members:

I hereby give consent for the disclosure of the information contained in the Action Plan for my student for the above described Potentially Life-Threatening Illness to all staff who may be involved in the implementation of the plan and to other appropriate staff. I acknowledge that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the school district, the Board, and its employees or agents against any claims arising out of the self-administration of medication by my child.

I give permission for _____ to self-administer _____ as prescribed by his/her physician.
(Student's Name) *(Medication)*

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

This permission form is effective only for the school year for which it is granted and must be renewed each school year.