RAWDAT AL-QURAN ACADEMY CHICAGO

ELEMENTARY SCHOOL

ALLERGY: Individual Health Care Plan

Diagnosis: Risk for anaphylaxis GOAL: Prevent allergic reaction at school.

Individual Health Care Plan for: _____

Allergies: _____

Grade/Teacher: _____

My child reacts to his/her allergen if he/she is near it, touches it, or consumes it?

_____

In the past my child's reaction symptoms included

_____

Medications used to stop the reactions included

_____

☐ My child will have emergency medications at school. ☐ Yes ☐ No

SCHOOL RESPONSIBILITY: Medications will be stored in the Front Office and staff who interact with students will be trained annually on anaphylactic emergencies.

PARENT RESPONSIBILITY: Medications must accompany current signed orders from a physician. It is the parent's responsibility to ensure that the school's supply is maintained and medications are not expired.

My child requires a “Nut Free” classroom. ☐ Yes ☐ No

SCHOOL RESPONSIBILITY: Teachers will ensure that foods used for class projects or experiments will not contain the student's allergen.

My child requires an allergen free eating area. ☐ Yes ☐ No

My child understands how to avoid exposure to his/her allergen. ☐ Yes ☐ No

I would like to accompany my child on field trips? _____

SCHOOL RESPONSIBILITY: Students not accompanied by a parent will be assigned to a staff member who will carry the emergency medication and who is trained to implement the Emergency Action Plan.

Parent/Guardian Signature: _____ 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 STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no 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 or severe diarrhea

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

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

⇩ ⇩ ⇩

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student 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 asthmatic): _____

_____

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

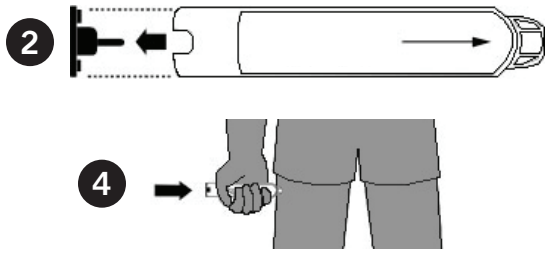
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

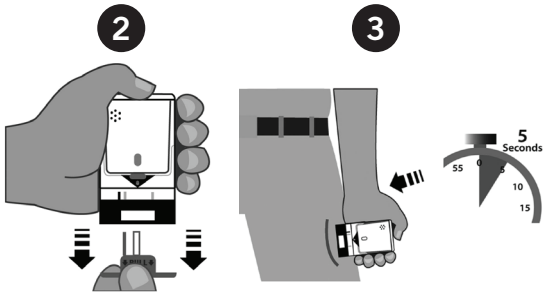
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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 student 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

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AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

(To Be Completed Annually by Physician)

Student Name: _____ Date of Birth: _____

School Year: _____ Grade and Teacher: _____

This child is under my medical care for _____ (Diagnosis) and medication is required during the school day.

Name of Drug	Dosage	Route	Frequency	Time To Be Given At School	Side Effects

☐ This student has been instructed in the self-administration of the above epinephrine auto-injector (ONLY), knows the circumstances under which to use the medication, and may carry the auto-injector. Prescriber's initials: _____

Signature of Physician: _____ Date: _____ OFFICE STAMP

Printed Name of Physician: _____ Physician's Office and Emergency Phone #: _____

Asthma Inhalers - Parents please attach prescription label to the back of this form if student is self-administering.

☐ My child has my permission to self-administer his/her asthma inhaler. Parent's initials: _____ By initialling here, the parent/guardian is responsible for the student carrying and maintaining their own inhaler.

To Be Completed By Parent or Legal Guardian

I give permission for my child to receive the above medication(s) as directed by the physician. I will bring the medication to the school nurse in a container labeled by the pharmacy. I will provide a written doctor's order if the medication dosage is changed or the medication is discontinued. For all medications other than self-administered asthma medications or epinephrine auto-injectors, I understand that it is the responsibility of the student to report to the RQA Front Office at the scheduled time to receive the medication. I further completely release and excuse RQA and its employees and agents of any liability or obligation of any nature in any way related to the school's medication policy and procedure.

“Self-administration” means that the student has the discretion as to the use of his/her asthma medication or epinephrine auto-injector (ONLY). Therefore, as the parent/guardian, I acknowledge that the student is responsible for having asthma medication or an epinephrine auto-injector available as needed, and that the student has demonstrated competency in the proper way to use the medication.

I, the parent/guardian of the above student acknowledge that, RQA Chicago Elementary School, along with its employees and agents, incur no liability as a result of any injury arising from the student's self-administration of asthma medication or epinephrine auto-injector. I indemnify and hold harmless the school, along with its agents and employees, against any claims (except a claim based upon willful and wanton conduct).

Parent signature and date: _____ Telephone: _____

Emergency contact name: _____ Telephone: _____