# ANAPHYLAXIS MANAGEMENT PARENT/STUDENT RESPONSIBILITIES

Family's Responsibility

- Will annually have an anaphylaxis management packet completed by your physician and provide to the school nurse, written medical documentation of the student's allergens, instructions, and medications as directed by a physician, using the Food Allergy & Anaphylaxis Emergency Care Plan.
- Provide properly labeled medications and replace medications timely after use or upon expiration.
- Provide a student photo on form where indicated.
- Work with the school team to develop a plan that accommodates the student's needs throughout the school, including in the classroom, in after-school programs, during school-sponsored activities, and on field trips.
- Educate the student in the self-management of their allergy including:
    - safe and unsafe foods/safe and unsafe environmental situations/environmental allergens including insects/bugs
    - strategies for avoiding exposure to unsafe foods/unsafe situations
    - symptoms of allergic reactions
    - how and when to tell an adult they may be having an anaphylactic allergy-related problem
    - how to read food labels (age appropriate), and know what may cause their individual anaphylaxis reaction
- Review policies/procedures with the school staff, the student's physician, and the student (age appropriate) after a reaction has occurred.
- Provide emergency contact information/update information if there are changes throughout the school year.

Student's Responsibility

- Will not trade food with others/ will not provoke insect stings or bites or put self in harmful anaphylactic potential situations.
- Will not eat anything with unknown ingredients or known to contain any allergen they are diagnosed having allergy to.
- Will avoid situations as able that are known or may potentiate a reaction, (for example, no swinging at insects, no heavy attractant fragrances).
- Will be proactive in the care and management of their anaphylaxis allergy/reactions based on their age and development level.
- Will notify an adult immediately if they eat something they believe may contain the food to which they are allergic or have been stung/bitten by known allergen causing insect or student has been exposed to environmental allergen that is causing symptoms of anaphylaxis.

I acknowledge that I have read and understand the above parent and student responsibilities and have discussed this with my child/student attending EDUPRIZE SCHOOLS.

Student's Name/Signature: _____ Date: _____

Parent Name and Signature: _____ Date: _____

# Allergy Parent Agreement

Dear Parent,

In response to better provide a safe environment for your child, we are asking that you complete, sign, and return this document immediately.

I, _____ the parent of _____, give EDUPRIZE SCHOOLS authorization to post my child/student's picture and pertinent medical information as needed in order to alert staff regarding potential medical concerns of my child.

I will also do the following:

- Meet with classroom teacher and nurse to discuss my child/student's health needs (Includes all causes of Anaphylaxis Allergens Diagnosed)
- Provide a list of safe snacks that my child can have (If anaphylaxis cause is food allergen)
- Instruct my child to not share snacks with others. (If anaphylaxis cause is food allergen)
- Provide snacks in a container labeled with the child's name (If anaphylaxis cause is food allergen)
- Provide "Wet Ones" brand antibacterial wipes (If anaphylaxis cause is food allergen)
- Provide medication for my student to manage child's anaphylaxis needs.

Student's Name: _____ Date:_____

Parent Signature: _____ Date:_____

Classroom Teacher: _____ Date:_____

# Consent for Allergy Needs Table Participation

(TO BE COMPLETED ONLY IF ANAPHYLAXIS IS CAUSED BY FOOD ALLERGEN)

In order to ensure the safety of your student/child, EDUPRIZE SCHOOLS has provided an allergy needs table for use during meal times for those students with allergies. Please indicate below whether you choose to have your student/child seated at the designated tables.

☐ Yes, I would like my student/child to be seated at the designated allergy needs table during meals.

☐ No, I would not like my student/child to be seated at the designated allergy needs table and I am aware that he/she may be exposed to allergens as a result.

Student's Name: _____ Grade: _____

Classroom Teacher: _____

Parent Signature: _____ Date: _____

# STUDENT CONSENT FORM for SELF CARRY/ADMINISTRATION OF MEDICATION

* Directions- Have a medical provider complete this page in order for your child to self-carry *

## A. Parent's Request and Authorization

I, THE UNDERSIGNED, request and authorize my child (student's name) _____ to carry and or self-administer his/her medication. List name of medication/s and condition for carrying while at school:

_____

_____

This authorization is given based on the following: Parent/Guardian initial below as indicated.

Initial _____ My child is capable of and has been instructed in the proper method of self-administration of this medication.

Initial _____ I understand that my child shall be permitted to carry his/her medication at all times as long as he/she does not endanger him/herself, endanger other persons, and/or will not misuse the medication.

Initial _____ I understand that if my child misuses or exceeds the prescribed dosage, or endangers others with with the medication, school employees or agents may confiscate the medication/s.

Initial _____ I understand that EDUPRIZE SCHOOLS, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child.

Initial _____ I shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child.

Initial _____ I understand that this authorization shall be in effect for the current school year and must be renewed annually, each school year.

Parent/Guardian Signature: _____ Date: _____

## B. Physician's Certification

I, THE UNDERSIGNED, certify that student (name) _____ has a life threatening condition/diagnosis (specify): _____.

He/ she has been instructed in the proper method of self-administration and is capable of carrying/self-administering his/her medication/s as listed above.

Physician's Name: _____ Physician's Signature: _____

Address: _____ Phone: _____ Date _____

# 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:**_____

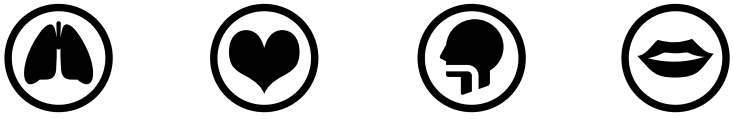
THEREFORE:

☐ 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

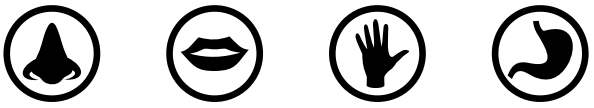
**OTHER**
Feeling something bad is about to happen, anxiety, confusion

**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

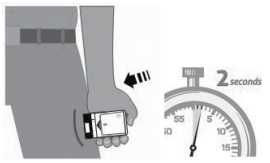
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

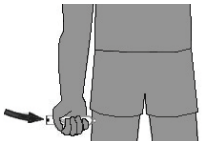
FARE
Food Allergy Research & Education

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



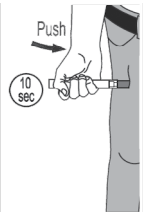

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

## 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: _____