Anaphylaxis Individual Emergency Care Plan – Pemberton Township Public Schools

Name: ______________________________ D.O.B.: ______________

Allergy to: ______________________________

Weight: ________ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Does student have a documented incident of anaphylaxis? ☐ Yes ☐ No

Extremely reactive to the following: ______________________________

Therefore:

☐ Give epinephrine immediately for **ANY** symptoms if there was a likely exposure.

☐ Give epinephrine immediately if there was exposure to the allergen, **even if no symptoms are noted**.

Otherwise:

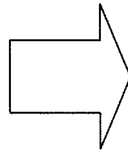
Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confuse
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

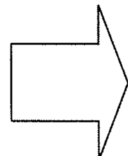


1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box on back page)
4. Give additional medications.*
   (If ordered)
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professional and parent
3. Dismiss student to care of parent or guardian
4. If symptoms progress (see above), USE EPINEPHRINE

Medication/Doses:

Epinephrine: ☐ 0.15mg **or** ☐ 0.3mg ☐ May repeat dose in 15 minutes if symptoms continue.

Antihistamine: ______________________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

*Please note that by NJ state law only the administration of epinephrine can be delegated to non-nursing school staff.

Self-Administration:

☐ I have instructed the above student in the proper administration of epinephrine/antihistamine. It is my opinion that he/she is capable of self-administration. Student must notify teacher or School Nurse when he/she has administered epinephrine/antihistamine.

OR

☐ It is my opinion that the above student **is not** capable of self-administration.

Contacts: Doctor: ______________________________ Phone: ______________

Parent/Guardian: ______________________________ Phone: ______________

Other Emergency Contact: ______________________________ Phone: ______________

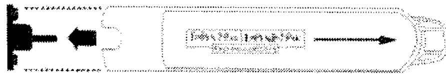
Doctor's Office Stamp

______________________________ ______________
Parent/Guardian Signature Date

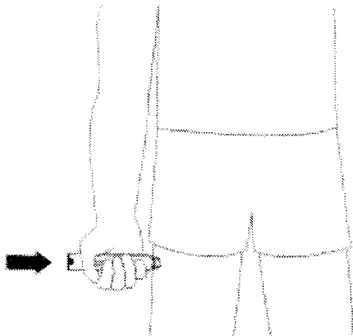
______________________________ ______________
Healthcare Provider Signature Date

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

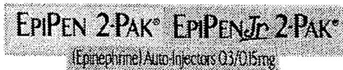


- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.

Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

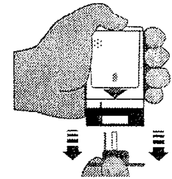


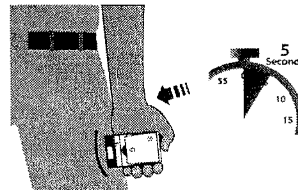
EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty L.P.

Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.





Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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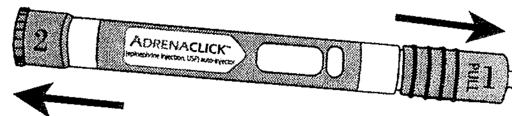
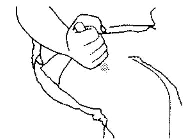
Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



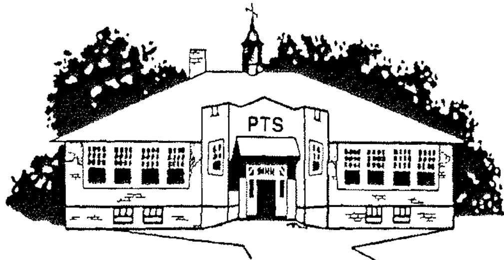
Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Monitoring

Stay with student; alert healthcare professionals and parent. Note time when epinephrine was administered and tell EMS. Give used epinephrine auto-injector to EMS for safe disposal. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See above for auto-injection technique.



PEMBERTON TOWNSHIP
SCHOOL DISTRICT
P.O. BOX 228, ONE EGBERT STREET
PEMBERTON, NEW JERSEY 08068-0228
PHONE: 609-893-8141

Food Allergy/Restriction Questionnaire

In order to ensure the safety of your child at school and assist the classroom teacher, we would like to ask you to complete in as much detail as possible, information regarding foods that your child may have for snack and what foods your child must absolutely avoid. Please be advised that this information will be shared with appropriate school personnel for the safety of your child.

If your child is allergic to nuts please specify which nuts they need to avoid and if there are any nuts they can safely eat. For example, allergy to walnuts and almonds but can have pecans and peanuts.

If your child is allergic to fruits please specify if it is the actual fruit only or if the allergy is to all forms of the fruit. Are artificial flavorings of the fruit acceptable? For example, allergy to apples but can have apple juice, applesauce or apple-flavored candy.

Please specify if the food product they are allergic to needs to be avoided all together or if a certain quantity is acceptable. For example, allergy to milk but can have 2 oz. a day of chocolate milk.

Finally, please provide us with suggested snacks that you normally would provide at home; be very specific about what your child must avoid.

Student name____ Grade____________________

Food allergy/restriction to ____

Avoid food totally or limit the amount? ____

May have a limited amount (be specific) ____

My child may be in the same room with other children eating this food product? Yes ☐ No ☐

My child must avoid the following prepared foods & baked goods __________________________

____

Snacks that my child can eat (be specific) ______________________________________

My child is allowed to self select items from the cafeteria and knows his/her restrictions? Yes ☐ No ☐
If the above answer is no, then you will need to pack a lunch for your child daily.

When my child has a reaction to eating this food you will see these symptoms____________________

____

Medications necessary to treat my child's reaction to this food allergy are______________________

If medication is needed at school additional paperwork needs to be completed by **you and your child's doctor**.

Check here ☐ if you need me to send the appropriate forms home to you **or circle from the sentence below**.

- My child has (**please circle all that apply**) been desensitized, no longer has a food allergy, medication is not required at school.

I will indemnify and hold the district and its employees harmless should any problems arise.

Parent Signature____ Date____________________