FOOD ALLERGY and ANAPHYLAXIS ACTION CARE PLAN

Child's Name: ____ Date of Birth: _____/_____/_____

Parent /Guardian: ____

Emergency Phone Numbers: Parent/Guardian: ___________________________________If no answer call: _______________________*(See emergency contact information for alternate contacts if parents are unavailable)*

Primary Health Care Provider: ____
Phone #: _______________________

Asthma and or Allergy Specialist: *(if any)* ____

Phone#: _________________________

To be completed by the Healthcare Provider/Physician

Allergy to: ____

Asthma: ☐Yes (higher risk for a severe reaction) ☐No

Extremely reactive to the following foods: ____

Environmental agents which may cause a reaction: ____

THEREFORE:

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

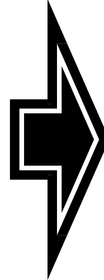
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
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, diarrhea, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & 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 professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Other Instructions: ____

____

Does this medication need to be transported on the bus with the child? __Yes ___ No

Medications/Doses

Epinephrine (brand and dose): ____

Antihistamine (brand and dose):

____

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

____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state and federal laws and regulations.

Health Care Provider Signature: ____

Date: ____________________

To be completed by the Parent/Guardian

I have developed this health plan in partnership with my child's healthcare provider and Head Start staff. I will communicate any changes in my child's identified health condition or treatment to Head Start staff as changes occur.

Effective _______________Expires ________________

This plan will be reviewed and updated annually.

As the parent/legal guardian of ____(Child's Name), I ______________________________(Parent/Guardian Name) give my Permission for OVEC Staff to administer the Emergency Action Plan including the administration of Medication as stated in this plan. I further release OVEC and its employees from any claims or liability connected with its reliance on this permission.

Parent/Guardian (print name) ___________________________________

Parent/Guardian Signature ___________________________________ Date: ______________

To be completed by Staff after being trained

By signature, staff acknowledges education by parent or guardian on condition(s) and requirement of emergency care and/or medication if needed.

(All staff in center must be trained):

Staff Signature ____________________________________ Date: ____________

Staff Signature ____________________________________ Date: ____________

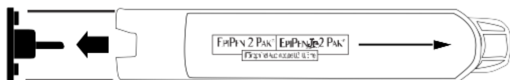
Staff Signature ____________________________________ Date: ____________

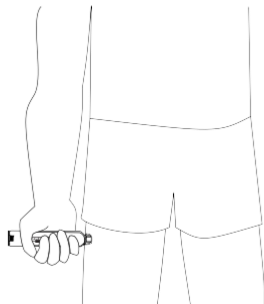
Staff Signature ____________________________________ Date: ____________

Staff Signature ____________________________________ Date: ____________

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EpiPen 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 thing for approximately 10 seconds.
- Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

DEY™ and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

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.

Emergency medications should accompany students as they move throughout the school grounds.

Emergency medication should not be locked up, but must remain out of reach of children at all times.

Ensure all medication is maintained in the original container and that the pharmacy label is on the container.