FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: ____________

Allergy to: ______________________

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

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ______________________

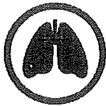
THEREFORE:

☐ 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:

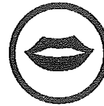
SEVERE SYMPTOMS



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

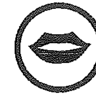
OR A COMBINATION of symptoms from different body areas.

1. **INJECT 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: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: ____________

Antihistamine Dose: ____________

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

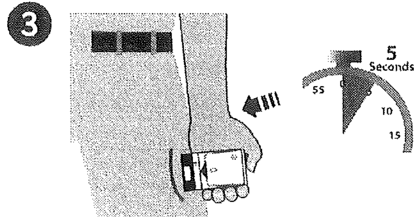
____

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

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

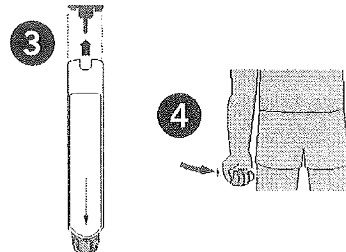
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



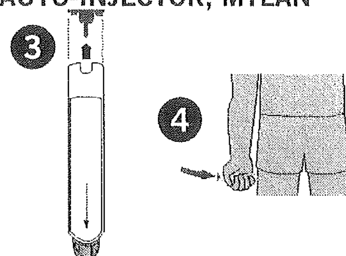
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



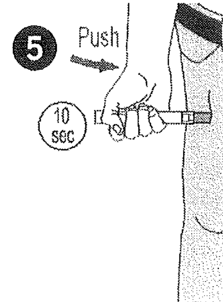
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. 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.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

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: ____________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2017

Return to Health Office

BOARD OF COOPERATIVE EDUCATIONAL SERVICES OF NASSAU COUNTY 2/16
HEALTH AND ALLIED SERVICES

PHYSICAL EXAMINATION

STUDENT_______________ BIRTH DATE_______________ DATE OF EXAM ___________

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received.
***An annual physical examination is required for participation in interscholastic sports. (*Both sides must be completed.)**

1. BP________ Pulse ________
2. Height ________Weight ________
   Body Mass Index:_____ _____ . _____
   Weight Status Category (BMI Percentile)
   ☐ less than 5th ☐ 5th- 49th ☐ 50th- 84th
   ☐ 85th- 94th ☐ 95th- 98th ☐ 99thand higher
3. Urinalysis________________
4. Heart ________________
5. Breasts ________________
6. Lungs ________________
7. Eyes R __________ L __________
   With Glasses R __________ L __________
8. Visual Diagnosis ________________
9. Ears: Otoscopic ________________
   Audiometric ________________
   P.E. tubes Yes ____ No _____
10. Speech________________
11. Nose ________________
12. Throat ________________
13. Tonsils ________________
14. Teeth and gums ________________
15. Skin ________________
16. Glands (cervical, thyroid, other) ___________
17. Nervous system ________________
18. Hernia ________________
19. Genitourinary ________________
20. Tanner I. II. III. IV. V.
21. Orthopedic: scoliosis: ☐ positive ☐ negative
    posture ______ feet ______
    structural defects____________
22. Abdomen ________________

SURGERIES: ________________________________

SIGNIFICANT ILLNESSES / INJURIES: ________________________________

ALLERGIES: ________________________________

CURRENT MEDICATIONS (please list all medications and dosages): ________________________________

____

MEDICAL SUMMARY WITH DIAGNOSIS: ________________________________

____

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity________ Restriction________ Recommendation________________________

** Please Attach Complete Record of Immunization**

________________________________ ____________ ________________________________
Signature of Examining Physician Date Print Name

Physician's Address & Phone #
(PLEASE STAMP)

INTERSCHOLASTIC SPORTS HEALTH EXAMINATION

Please complete both sides for participation in interscholastic sports.

This certifies that ______________________________________ is physically qualified to participate in the following categories of competition during this school year **except** those crossed out below.

CONTACT / COLLISION	LIMITED CONTACT / IMPACT	STRENUOUS NON-CONTACT	NON-STRENUOUS / NON-CONTACT
Field Hockey Football Ice Hockey Lacrosse Soccer Wrestling	Baseball Basketball Cheerleading Diving Gymnastics Handball Skiing Cross Country Downhill Softball Volleyball	Crew Cross Country Track & Field Swimming Tennis	Archery Bowling Golf

Physician
Signature: ____ Date: __________
Family Physician

- -

The school physician has the final responsibility for the determination of a student's physical eligibility to participate in interscholastic sports. This is in compliance with the State Education Department Regulation 135.4 (7) (h).

This student is cleared for participation in interscholastic sports as indicated above.

Physician
Signature: ____ Date: __________
School Physician

BOARD OF COOPERATIVE EDUCATIONAL SERVICES OF NASSAU COUNTY
HEALTH AND ALLIED SERVICES

SPORTS HEALTH UPDATE

Date: ___________

Dear Parent or Guardian:

Your child had been examined and approved for participation in interscholastic sports for this school year. A health history review is required prior to tryouts for each sports season. A re-examination and re-qualification may be required to participate in interscholastic sports for this season.

Please respond to the questions below and return this letter to the health office. If you have any questions, please call me at _____________.

Sincerely,

School Nurse

- -

Student:____

Sport:____

*Answering "Yes" to any of the questions will not automatically exclude the student from participation.

Since the interscholastic sports physical has your child

Had any injuries requiring medical attention?	Yes ☐	No ☐
Had an illness lasting more than 5 days?	Yes ☐	No ☐
Been taking any medication or been under a doctors care?	Yes ☐	No ☐
Had any surgery or fractures?	Yes ☐	No ☐
Been treated in a hospital or emergency room?	Yes ☐	No ☐
Developed any allergies or chronic disease?	Yes ☐	No ☐
Reported feeling faint, dizzy or fatigued after exercise or exertion?	Yes ☐	No ☐
Had a change in wearing glasses or contact lenses?	Yes ☐	No ☐

If the answer to any of the above is yes, please describe below and **attach a note from the physician** clearing the student for participation in interscholastic sports. (Please understand that the school physician has the final authority to determine the physical capability of a student to participate in a sport.)

____

____

Parent/Guardian Signature:__________________________________ Date:__________