SELA: THE INTERNATIONAL PRIVATE SCHOOL

Allergy Information Form for Parents/Guardians

*SELA: The International Private Schools' Life-Threatening Allergies (LTA) Policy and Guidelines can be found in our Health Policies available on our website at suescuela.com by looking under about and then clicking on SELA's Health Policies. Please read the LTA Policy/Protocol, especially parent and student responsibilities sections.

1. Name:_____DOB:_____Program or Grade:_____

2. ALLERGY/ALLERGIES:_____

3. Age at Onset of Allergy: _____ **In the past reaction has occurred:**

- Never; only positive skin/blood test to:_____
- With ingestion---describe which allergen; reaction and treatment:
  _____
- With skin contact---describe which allergen; reaction and treatment:
  _____

4. Is the student followed by an allergist? YES_____ NO _____

5. If yes, name of MD _____ Date of last visit: _____ Contact # _____

6. Does the student have an Epinephrine auto injector? YES _____ NO _____

Please provide an auto injector two pack for the school **on or before the first day of school with a new medication order signed by the PCP/Allergist and parental signature.** Auto injectors must be in their original prescription box. If an antihistamine is included on the action plan, this must be provided to the school in a new, unopened box labeled with the child's name **on or before the first day of school**.

7. Asthma: YES _____ NO _____ Inhaler Required in school? Yes _____ No _____

The above information will help us to better understand your child's allergy and create a plan of care specific for your child. Please ensure that the PCP or Allergist completes and signs the **"Anaphylaxis Emergency Action Plan" and "Epinephrine Auto-Injector Medication Authorization Form"** enclosed. Your signature is also required. **If your child's PCP includes an antihistamine on their emergency action plan**, please ensure that the PCP completes and signs the **"Antihistamine Medication Authorization Form**" enclosed. Your signature is also required.

I give permission to the school nurse or director to:

--Discuss the health needs of my child with all pertinent school staff

--Contact the Primary Care Physician and/or Allergist to discuss health concerns of my child if necessary

Parent Signature: _____ Date: _____

SELA: THE INTERNATIONAL PRIVATE SCHOOL

Epinephrine Auto-injector Medication Authorization Form

*The following section is to be completed by the **Parent:***

Child's Name:_____ DOB: _____ Program or Grade: _____

Food/Insect Allergies: _____

Physician's Name: _____ Address: _____ Phone #: _____

I give permission for the school nurse and/or director to share with appropriate school personnel information relative to the prescribed medication administration, as he/she determines necessary for my son/daughter's health and safety: ☐ Yes ☐ No Any restrictions on release:

_____

I give permission for the school nurse and/or director to contact the Physician, PA or Nurse Practitioner listed below: ☐ Yes ☐ No

I request that my child be administered the medication described below in the event of an anaphylactic emergency as detailed on my child's emergency action plan by trained authorized personnel. *(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or by the end of the school year.)*

Parent/Guardian:_____ _____ _____

Please print name *Signature* *Date*

*The following section is to be completed by the ordering **Physician, PA, or Nurse Practitioner:***

Diagnosis for which medication is ordered:
Medication: **Epinephrine Jr. 0.15 mg ☐ Epinephrine SR. 0.3 mg ☐ Auvi-Q 0.15 mg ☐ Auvi-Q 0.3 mg ☐ Other Medication ☐ Name and Dose:**
Route of administration: **Auto-injector**
List significant side effects/adverse reactions:
How soon can it be repeated, if desired:
Date to start: **Date to stop:**
Any other medical condition(s):
Other medication taken by the student:
Other information:

Physician, PA, Nurse Practitioner Signature: _____Date: _____

SELA: THE INTERNATIONAL PRIVATE SCHOOL

Antihistamine Medication Authorization Form

Please note: this form is ONLY required if your child's doctor includes an antihistamine on the emergency action plan.

*The following section is to be completed by the **Parent:***

Child's Name:_____ DOB: _____ Program or Grade: _____

Diagnosis: _____

Physician's Name: _____ Address: _____ Phone #: _____

I give permission for the school nurse and/or director to share with appropriate school personnel information relative to the prescribed medication administration, as he/she determines necessary for my son/daughter's health and safety: ☐ Yes ☐ No Any restrictions on release:

_____

I give permission for the school nurse and/or director to contact the Physician, PA or Nurse Practitioner listed below: ☐ Yes ☐ No

I request that my child be administered the medication described below in accordance with the details on my child's emergency action plan by trained authorized personnel. *(Please note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or by the end of the school year.)*

Parent/Guardian:_____ _____ _____

Please print name *Signature* *Date*

*The following section is to be completed by the ordering **Physician, PA, or Nurse Practitioner:***

Diagnosis for which medication is ordered:	
Medication:	
Dosage:	
Route:	
List significant side effects/adverse reactions:	
How soon can it be repeated, if desired:	
Date to start:	**Date to stop:**
Any other medical condition(s):	
Other medication taken by the student:	
Other information:	

Physician, PA, Nurse Practitioner Signature: _____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:_____

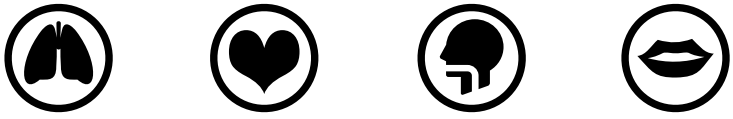
THEREFORE:

☐ 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

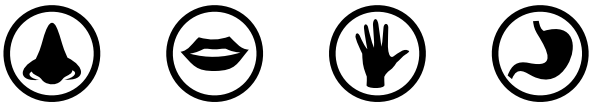
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **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: ☐ 0.1 mg IM ☐ 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

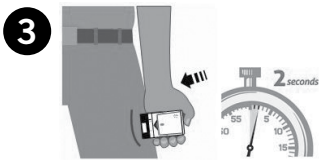
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

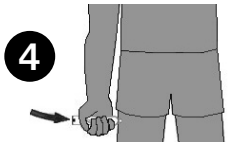
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



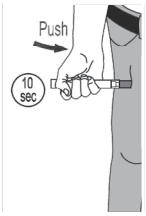
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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. 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.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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: _____

NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020