AMERICAN LEADERSHIP ACADEMY

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

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: _____

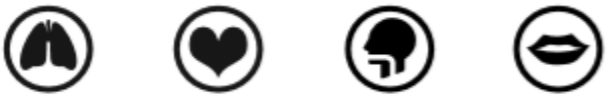
THEREFORE:

☐ 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: ☐ 0.1 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) 5/2018

(If student is a bus rider please give copy of this plan to transportation)

AMERICAN LEADERSHIP ACADEMY

FARE Food Allergy Research & Education

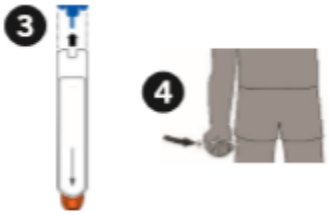
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPRHINE 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 until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

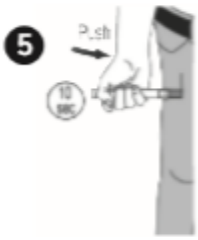
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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.
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.



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.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. 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: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

AMERICAN LEADERSHIP ACADEMY

FARE Food Allergy Research & Education

PLAN DE ATENCIÓN DE EMERGENCIAS DE ALERGIAS ALIMENTARIAS Y ANAFILAXIA

Nombre _____ Fecha de nacimiento: _____

Alérgico a: _____

Peso: _____ kilos. Asma: ☐ **Sí (Riesgo más alto de reacción grave)** ☐ **No**

NOTA: No recurra a antihistamínicos ni inhaladores (broncodilatadores) para tratar una reacción grave. UTILICE EPINEFRINA.

Extremadamente reactivo a los siguientes alérgenos: _____

POR LO TANTO:

☐ Si esta opción está marcada y es PROBABLE que se ha ingerido el alérgeno, administre epinefrina de inmediato ante CUALQUIERA de estos síntomas.

☐ Si esta opción está marcada y es SEGURO que se ha ingerido el alérgeno, administre epinefrina de inmediato aunque no se observe ningún síntoma.

ANTE **CUALQUIERA** DE LOS SIGUIENTES: SÍNTOMAS **GRAVES**

PULMÓN
Falta de aire, sibilancia, mucha tos

CORAZÓN
Tez azulada o pálida, desmayo, pulso débil, mareo

GARGANTA
Ronquera u oclusión, dificultad para tragar o respirar

BOCA
Hinchazón significativa de la lengua o los labios

PIEL
Urticaria extendida en las distintas partes del cuerpo, enrojecimiento generalizado

INTESTINOS
Vómitos reiterados, diarrea grave

OTRO
Sensación de que va a pasar algo malo, ansiedad, confusión.

O UNA COMBINACIÓN
de los síntomas de las distintas áreas

1. **INYECTE EPINEFRINA DE INMEDIATO**
2. **Llame al 911.** Avise al operador telefónico que el paciente tiene anafilaxia y puede necesitar epinefrina cuando llegue el equipo de emergencia.

- Considere la administración de otros medicamentos además de la epinefrina:
  - -Antihistamínico
  - -Inhalador (broncodilatador) en caso de respiración sibilante
- Mantenga al paciente en posición horizontal, con las piernas en alto y abrigado. Si tiene dificultades para respirar o vómitos, manténgalo sentado o tendido sobre un costado.
- Si los síntomas no mejoran o vuelven a aparecer, puede administrar otras dosis adicionales de epinefrina a partir de los 5 minutos de la administración de la última dosis.
- Comuníquese con los contactos de emergencia.
- Lleve al paciente a la sala de emergencias, aunque los síntomas hayan desaparecido. (El paciente debe permanecer en la guardia médica durante por lo menos 4 horas porque los síntomas pueden reaparecer).

SÍNTOMAS **LEVES**

NARIZ
Picazón o moqueo nasal, estornudos

BOCA
Picazón bucal

PIEL
Algunas ronchas, picazón leve

INTESTINO
Náuseas leves o malestar

EN CASO DE **SÍNTOMAS LEVES** EN **MÁS DE UN ÁREA** DEL CUERPO, ADMINISTRE EPINEFRINA.

EN CASO DE **SÍNTOMAS LEVES** EN UN **ÁREA ÚNICA** SIGA ESTAS INSTRUCCIONES:

1. Se pueden administrar antihistamínicos, con prescripción médica.
2. Quédese junto a la persona; comuníquese con los contactos de emergencia.
3. Observe atentamente los posibles cambios. Si los síntomas empeoran, administre epinefrina.

MEDICAMENTOS/DOSIS

Marca de epinefrina o fármaco genérico: _____

Dosis de epinefrina: ☐ 0,1 mg IM ☐ 0,15 mg IM ☐ 0,3 mg IM

Marca de antihistamínico o fármaco genérico: _____

Dosis de antihistamínico: _____

Otros (por ejemplo, broncodilatador en caso de sibilancia): _____

_____

FIRMA DE AUTORIZACIÓN DEL PACIENTE O PADRE/TUTOR FECHA FIRMA DE AUTORIZACIÓN DEL MÉDICO O PROFESIONAL DE SALUD INTERVINIENTE FECHA

FORMULARIO SUMINISTRADO POR CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

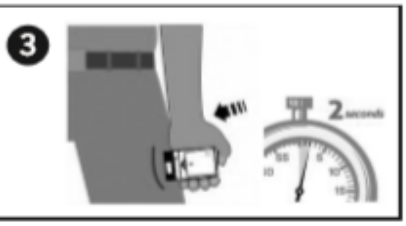
AMERICAN LEADERSHIP ACADEMY

FARE Food Allergy Research & Education

PLAN DE ATENCIÓN DE EMERGENCIAS DE ALERGIAS ALIMENTARIAS Y ANAFILAXIA

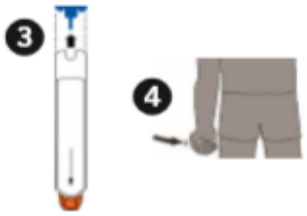
CÓMO UTILIZAR AUVI-Q® (INYECCIÓN DE EPINEFRINA, USP), KALEO

1. Retire AUVI-Q del estuche externo.
2. Saque la tapa de seguridad roja.
3. Coloque el extremo negro de AUVI-Q® contra la parte exterior media del muslo.
4. Oprima firmemente hasta escuchar un clic y un silbido, mantenga presionado por 2 segundos.
5. Llame al 911 y pida asistencia médica de emergencia de inmediato.



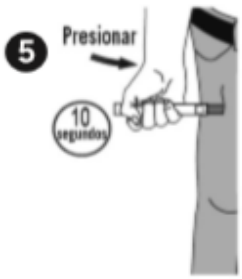
CÓMO USAR EL AUTOINYECTOR DE EPINEFRINA EPIPEN® Y EPIPEN JR® Y LA INYECCIÓN DE EPINEFRINA (FÁRMACO GENÉRICO AUTORIZADO DE EPIPEN®), USP (AUTOINYECTOR), MYLAN

1. Retire el autoinyector Epipen® o EpiPen Jr® del tubo transparente.
2. Sujete el autoinyector firmemente con el puño con la punta naranja (el extremo de la aguja) apuntando hacia abajo.
3. Con la otra mano, retire el protector de seguridad azul tirando firmemente hacia arriba.
4. Gire y oprima con firmeza el autoinyector contra la parte exterior media del muslo hasta que haga clic.
5. Sostenga firmemente en el lugar durante 3 segundos (cuente lentamente 1, 2, 3).
6. Retire el dispositivo y masajee el área durante 10 segundos.
7. Llame al 911 y pida asistencia médica de emergencia de inmediato.



CÓMO UTILIZAR LA INYECCIÓN DE EPINEFRINA IMPAX (GENÉRICO AUTORIZADO DE ADRENACLICK®), USP, AUTOINYECTOR, LABORATORIOS IMPAX

1. Retire del autoinyector de epinefrina de su estuche protector.
2. Saque las dos tapas de extremo azul. Ahora podrá ver una punta roja.
3. Sujete el autoinyector firmemente con el puño con la punta roja apuntando hacia abajo.
4. Coloque la punta roja contra la parte exterior media del muslo en un ángulo de 90°, en posición perpendicular al muslo.
5. Oprima y sostenga con firmeza durante aproximadamente 10 segundos.
6. Retire el dispositivo y masajee el área durante 10 segundos.
7. Llame al 911 y pida asistencia médica de emergencia de inmediato.



INFORMACIÓN DE ADMINISTRACIÓN Y SEGURIDAD PARA TODOS LOS AUTOINYECTORES:

1. No coloque el dedo pulgar, los demás dedos o la mano sobre la punta del autoinyector ni aplique la inyección fuera de la parte exterior media del muslo. En caso de inyección accidental, diríjase inmediatamente a la sala de emergencias más cercana.
2. Si administra el medicamento a un niño pequeño, sostenga su pierna firmemente antes y durante la aplicación para evitar posibles lesiones.
3. Si es necesario, la epinefrina se puede aplicar a través de la ropa.
4. Llame al 911 inmediatamente luego de aplicar la inyección.

INSTRUCCIONES/INFORMACIÓN ADICIONAL (la persona puede llevar epinefrina, el paciente puede autoadministrarse la medicación, etc.):

Trate a la persona antes de llamar a los contactos de emergencia. Las primeras señales de una reacción pueden ser leves, pero los síntomas pueden agravarse con rapidez.

CONTACTOS DE EMERGENCIA – LLAME AL 911

EQUIPO DE RESCATE: _____

MÉDICO: _____ TELÉFONO: _____

PADRE O TUTOR: _____ TELÉFONO: _____

OTROS CONTACTOS DE EMERGENCIA

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

NOMBRE/RELACIÓN: _____

TELÉFONO: _____

FORMULARIO SUMINISTRADO POR CORTESÍA DE FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

AMERICAN LEADERSHIP ACADEMY

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form *Request for Medication Administration in School* from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for all prescription drugs and naturopathic remedies, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the written instructions on the label.
   (Please read initial and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.
5. School personnel will not administer any prescription medication or naturopathic remedy to a student unless the school has received a completed *Request for Medication Administration in School* form that has been signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container.
   If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse

Thank you for your cooperation,

School Nurse **Date**

Director **Date**

AMERICAN LEADERSHIP ACADEMY

The Responsibility of the Parent or Legal Guardian

1._____ Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.

2._____ Parents may choose to administer the medication at school themselves.

3._____ Medication must be delivered to the Health Office **by the parent or other responsible delegated adult**.

4._____ Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form *Request for Medication Administration in School* form. Return completed form to school.

5._____ A separate parent request/permission form must be completed for each medication given at school.

6._____The *Request for Medication Administration in School* form must be signed by a health care provider licensed to prescribe medications and include the following details:

a. Name of child and name of medication
b. Dose, route and time of medication to be given
c. Any special instructions about the child receiving the medication or about the medicine itself.
d. Start and Stop date of the medication
e. Possible side effects and/or adverse reactions to the medication
g. Name of the health care provider and how to locate or communicate with him or her if necessary

7._____ Provide the school with a new *Request for Medication Administration in School* form when there are any changes to the above details.

8._____ Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

9._____ Provide the school with new, labeled containers when dosage or medication changes are prescribed.

10._____ Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.

11._____ Over the counter medications will be dispensed by health office personnel to students who have written permission from a parent or guardian to receive medication at school, as needed, for a maximum of three consecutive days. To ensure that use of this medication is not masking symptoms of a serious condition in the student, a healthcare provider's order must be submitted to the school health office for administration beyond this three-day period. OTC medications will not be dispensed during the first and last hours of the school day unless approved on a case by case basis.

12_____ For the protection of all, students are not permitted to have medications in their possession—with the exception of inhalers, EpiPens and diabetic medications and supplies, for which written permission has been given by the child's physician and parents.

13._____Retrieve all unused medications from school when medications are discontinued, and/or at end of school year (According to ALA policy) medications will be discarded 3 days from the end of the school year. Medications will not be sent home with students.

14._____ Maintain communication with staff regarding any changes to the medical treatment or child's need at school.

Parent Signature **Date**

AMERICAN LEADERSHIP ACADEMY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.:_____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

_____

Contraindications to administration: _____

Physician *(printed)* **Name**: _____ Address:_____

Physician Contact Information: Phone: _____ Fax:_____

Physician's Signature: _____ Date: _____

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to American Leadership Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____Date: _____

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

AMERICAN LEADERSHIP ACADEMY

Medication Administration Record (2020-2021)

A separate sheet is used for each medication or treatment

Key : A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early Dismissal

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
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Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

AMERICAN LEADERSHIP ACADEMY

Student Agreement for Self-Carried Medication

Student: _____**Grade:** _____

Campus: _____

Parent(s) Printed name: _____

Parent(s) Contact Numbers: _____

Health Care Provider: _____**Phone Number :** _____

Type of Medication: ☐ Asthma Inhaler ☐ Epinephrine Auto-Injector ☐ Diabetic Medication/Supplies

Medication: _____ **Dose and Time:** _____

Medication is permitted in accordance with state laws and district policy, both student's health care provider and parent guardian must complete Medication Authorizations Form. Students name must appear on medications and devices.

Student Responsibilities

- *I will keep my asthma inhaler, Epinephrine Auto Injector, or diabetes medication/supplies with me at school.*
- *I agree to use my asthma inhaler, Epinephrine Auto-Injector, or diabetes medication/supplies in a responsible manner, in accordance with my licensed health care providers orders.*
- *I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition*
- *I will not allow any other person to use my medication or equipment.*

Student Signature: _____**Date:** _____

___ Emergency Action Plan complete and on file at school
___ Demonstrates correct use/administration
___Verbalizes proper and prescribed timing for medication
___Can describe own health condition well
___Keeps a second labeled container in health office or main office
___Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that American Leadership Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____ Date: _____

Emergency Contact: Name: _____ Phone Number: _____

Health Aide Signature: _____ Date: _____