DE PAUL CATHOLIC
HIGH SCHOOL

1512 Alps Road, Wayne, NJ 07470-3695
973.694.3702 | Fax: 973.633.5381 | http://www.depaulcatholic.org

Dear Parent/Guardian:

Enclosed is the necessary paperwork to be completed by both physician and parent for this school year (20___-20___). Please fill in completely and return to the school's health office as soon as possible. This paperwork is required so that your child can be cared for properly and so that he/she may self-administer their Epi-Pen (epinephrine) in school.

**If this does not pertain to your child, please fill in only the second page and return it to the health office and no further paperwork from this packet is required.*

If you have any concerns or questions please feel free to contact the school's nurse at school 973-694-3702, x 270; fax 973-694-6232. Thank you for your anticipated cooperation in this matter.

School Health Office

2/15/17

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Dear Parent /Guardian,

We are updating our health records for this 20____- 20____ school year. In your child's health records from the past, it states that your child had allergies and may need to carry an epinephrine injection pen (Epi-Pen) for emergencies. Please indicate your response by checking off the appropriate boxes and returning this form to the nurse's office as soon as possible. We are trying to reduce unnecessary paperwork for you and our health office. Thank you in advance for your cooperation.

Child's Name _____ Allergy History Of: _____

- ☐ *My child no longer has this diagnosis and does not need any medication, including Benadryl or epinephrine (No further paperwork needs to be completed from this packet).*
- ☐ *My child never had this diagnosis (No further paperwork needs to be completed from this packet).*
- ☐ *My child must use an Epi-Pen and will carry pen with him/her.*
- ☐ *My child must use Epi-pen and will keep one available in the nurse's office.*
- ☐ *Other Comments* _____

Parent Name: _____ *Date:* _____

Parent Signature: _____

2/5/17

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Date: _____

To: Parents/Guardians:

Re: 20___-20___ Food Allergy & Anaphylaxis Emergency Care Plan

Please review and sign the attached forms, including the FARE form (Food Allergy & Anaphylaxis Emergency Care Plan) (http://www.foodallergy.org/document.doc?id=234).

The FARE form addresses:

- **Severe Symptoms**
- **Mild Symptoms**
- **Medication/Doses**
- **Directions – Epipen Auto Injector**
- **Directions – Adrenaclick**

In addition, please sign and return this memo along with the FARE form (which requires parent and physician signatures).

As per parent/guardian of the student listed below, I understand that if the procedures as specified in N.J.S.A. 18A:40-12.6 are followed, the district or non public school shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district, non public school, and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.

Student's Name:_____ **School: De Paul Catholic High School**

Physician Signature:_____ Date _____ Phone: _____

Parent/Guardian Signature:_____ Date _____ Phone: _____

Thank you

Rev: 2/15/17

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**

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
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/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/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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): _____

_____

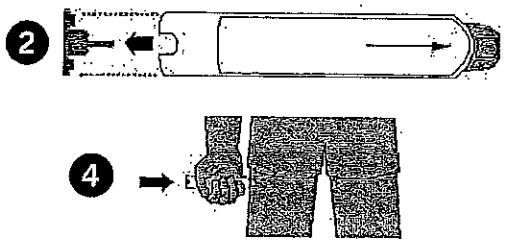
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

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

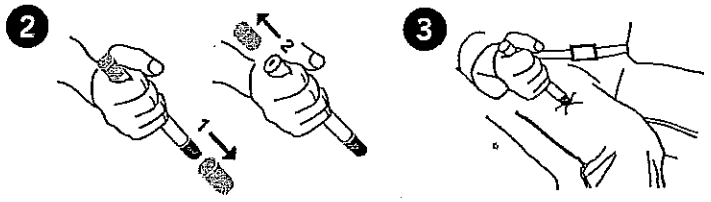
EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



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: _____

Please See Attached "Emergency Information Card"

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

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PERMISSION TO SHARE INFORMATION
20___-20___

As you are aware, everyday each of our students has contact with a variety of staff members: teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include: known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes**, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No**, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____

Parent/Guardian Signature Date

DE PAUL CATHOLIC HIGH SCHOOL 20___ - 20___
EMERGENCY INFORMATION CARD

Please Print Grade_____

Student's Name_____

Address_____ Home Tel._____

City _____ Birth Date _____

Where parents can be reached between 7:30 AM – 3 PM (work #):

Mother:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

Father:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

1. Name _____ Tel.#1 _____
   Tel #2_____
   Address _____ City_____
2. Name _____ Tel.#1_____
   Tel.#2_____
   Address_____ City_____

Date _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Signature of parent or guardian _____

Remarks: _____

Allergies: _____

Other Conditions: _____

Local Physician's Name _____

Address _____City _____

Office Tel. No. _____ Other Tel No. _____