Packet B

FOOD ALLERGY Children

Here is the Food Allergy Action Plan to be filled out by your doctor.

There is also the Medication Administration Authorization Form. Make a separate copy of this form for each medication that the doctor prescribes for your child.

This needs to be turned in AT LEAST one week before your camp session begins, along with the medication/s.

Thank you

First Aid Director

Day Camp
Emergency Health Care Plan

ALLERGY TO: ________________________________

Child's Name: ___________________________ DOB: _______ Child Care Provider _______________________

History of Asthma  □ Yes (high risk for severe reaction)  □ No

Signs of an allergic reaction include:

**Systems**  **Symptoms**

MOUTH  Itching & swelling of lips, tongue, or mouth

*THROAT  Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough

SKIN  Hives, itchy rash, and/or swelling about the face or extremities

GUT  Nausea, abdominal cramps, vomiting and/or diarrhea

*LUNG  Shortness of breath, repetitive coughing, and/or wheezing

*HEART  "Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

**ACTION:** If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)

_________ Observe child for severe symptoms

_________ Administer EpiPen® before symptoms occur

_________ Administer EpiPen® if symptoms occur

_________ Administer Benadryl® (dose) or Atarax® (dose)

_________ Call 911 (and request a paramedic) and transport to ER if symptoms occur

_________ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: ________________________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!

Parent Signature ____________________________ Date __________ Prescriber Signature MD/APRN/PA ____________________________ Date __________

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<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>1. Name</th>
<th>Trained Y/N</th>
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<th>Relation</th>
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Nurse Consultant: ____________________________ Date: __________

For children with multiple allergies, use one form for each allergen.
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child’s name, name of medication, directions for medication’s administration, and date of the prescription.

Authorized Prescriber’s Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student __________________________ Date of Birth ___/___/___ Today’s Date ___/___/___
Address of Child/Student __________________________ Town __________________________
Medication Name/Generic Name of Drug __________________________ Controlled Drug? □ YES □ NO
Condition for which drug is being administered: _____________________________________________
Specific Instructions for Medication Administration

Dosage __________________________ Method/Route __________________________
Time of Administration __________________________ If PRN, frequency __________________________
Medication shall be administered: Start Date: ___/___/___ End Date: ___/___/___
Relevant Side Effects of Medication __________________________ □ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs __________________________

Plan of Management for Side Effects __________________________

Prescriber’s Name/Title __________________________________________ Phone Number (_____) __________
Prescriber’s Address __________________________________________ Town __________________________
Prescriber’s Signature __________________________ Date ___/___/___

School Nurse Signature (if applicable) __________________________

Parent/Guardian Authorization:

□ I request that medication be administered to my child/student as described and directed above

□ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

□ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature __________________________ Relationship ______________ Date ___/___/___
Parent/Guardian’s Address __________________________________________ Town ______________ State __________
Home Phone # (_____) __________ Work Phone # (_____) __________ Cell Phone # (_____) __________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.

Prescriber’s authorization for self-administration: □ YES □ NO __________________________ Signature ______________ Date ___/___/___

Parent/Guardian authorization for self-administration: □ YES □ NO __________________________ Signature ______________ Date ___/___/___

School nurse, if applicable, approval for self-administration: □ YES □ NO __________________________ Signature ______________ Date ___/___/___

Today’s Date __________ Printed Name of Individual Receiving Written Authorization and Medication __________________________

Title/Position __________________________ Signature (in ink or electronic) __________________________

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v,)
**RECORD OF EMERGENCY MEDICATION ADMINISTRATION**

Child’s Name: ___________________________ DOB __________

Address: _____________________________

Parent/Guardian Name: __________________ Phone (W) __________ Phone (H) __________

Name of Medication ___________________________ Date Received __________

Dose ___________________________ Route ___________________________ Frequency __________

**Special Instructions**

Name of Authorized Prescriber: ___________________________ Start Date __________ Stop Date __________

Prescription # ___________________________ Date of Prescription __________

Pharmacy ___________________________ Phone: __________

Allergies ___________________________ Side Effects ___________________________

Time of Occurrence ___________________________ Symptoms: ___________________________

911 Called ___________________________ (time) Parents called ___________________________ (time)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dose</th>
<th>Route and/or site of injection</th>
<th>Level of Cooperation</th>
<th>Side Effects</th>
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Staff Signature ___________________________

Time of Occurrence ___________________________ Symptoms: ___________________________

911 Called ___________________________ (time) Parents called ___________________________ (time)

<table>
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Staff Signature ___________________________
# Food Allergy Action Plan

**Name:** ___________________________  **D.O.B.:** ___ / ___

**Allergy to:** ___________________________

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

**Extremely reactive to the following foods:**

**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.

<table>
<thead>
<tr>
<th>Any SEVERE SYMPTOMS after suspected or known ingestion:</th>
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<tbody>
<tr>
<td><strong>One or more</strong> of the following:</td>
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<tr>
<td><strong>LUNG:</strong> Short of breath, wheeze, repetitive cough</td>
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<tr>
<td><strong>HEART:</strong> Pale, blue, faint, weak pulse, dizzy,</td>
</tr>
<tr>
<td>confused</td>
</tr>
<tr>
<td><strong>THROAT:</strong> Tight, hoarse, trouble breathing/swallowing</td>
</tr>
<tr>
<td><strong>MOUTH:</strong> Obstructive swelling (tongue and/or lips)</td>
</tr>
<tr>
<td><strong>SKIN:</strong> Many hives over body</td>
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<tr>
<td><strong>Or combination</strong> of symptoms from different body areas:</td>
</tr>
<tr>
<td><strong>SKIN:</strong> Hives, itchy rashes, swelling (e.g., eyes, lips)</td>
</tr>
<tr>
<td><strong>GUT:</strong> Vomiting, crampy pain</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MILD SYMPTOMS ONLY:</th>
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</thead>
<tbody>
<tr>
<td><strong>MOUTH:</strong> Itchy mouth</td>
</tr>
<tr>
<td><strong>SKIN:</strong> A few hives around mouth/face, mild itch</td>
</tr>
<tr>
<td><strong>GUT:</strong> Mild nausea/discomfort</td>
</tr>
</tbody>
</table>

## Medications/Doses

<table>
<thead>
<tr>
<th>Epinephrine (brand and dose):</th>
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<tbody>
<tr>
<td>Antihistamine (brand and dose):</td>
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<tr>
<td>Other (e.g., inhaler-bronchodilator if asthmatic):</td>
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</tbody>
</table>

## 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.

**Parent/Guardian Signature** ___________________________  **Date:** ____________

**Physician/Healthcare Provider Signature** ___________________________  **Date:** ____________

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**Form provided courtesy of FAAN (www.foodallergy.org) 7/2010**
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 thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled “1” and “2.”

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don’t improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

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.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student’s physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (__) - ___) Doctor: ___
Parent/Guardian: ___

Phone: (__) - ___

Other Emergency Contacts

Name/Relationship: ___
Name/Relationship: ___

Phone: (__) - ___
Phone: (__) - ___

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010