

ST. THERESE SCHOOL Nurse's Office

135 Main Street, Succasunna NJ 07876

Tel: 973-584-0812 x104

Food Allergy/Restriction Questionnaire

In order to ensure the safety of your child at school and assist the classroom teacher, we would like to ask you to complete in as much detail as possible, information regarding foods that your child may have for snack and what foods your child must absolutely avoid. Please be advised that this information will be shared with appropriate school personnel for the safety of your child.

If your child is allergic to nuts please specify which nuts they need to avoid and if there are any nuts they can safely eat. For example, allergy to walnuts and almonds but can have pecans and peanuts.

If your child is allergic to fruits please specify if it is the actual fruit only or if the allergy is to all forms of the fruit. Are artificial flavorings of the fruit acceptable? For example, allergy to apples but can have apple juice, applesauce or apple-flavored candy.

Please specify if the food product they are allergic to needs to be avoided all together or if a certain quantity is acceptable. For example, allergy to milk but can have 2 oz. a day of chocolate milk.

Student Name: _____ Grade: _____

Food allergy/restriction to: _____

Avoid food totally or limit the amount? _____

May have a limited amount (be specific): _____

My child may be in the same room with other children eating this food product? Yes: _____ No: _____

My child must avoid the following prepared foods & baked goods: _____

Snacks that my child can eat (be specific): _____

My child is permitted to self-select food items and knows his/her restrictions? Yes: _____ No: _____

If the above answer is NO, please provide snacks that your child may have during parties/special occasions.

When my child has a reaction to eating this food you will see these symptoms: _____

Medications necessary to treat my child's reaction to this food allergy are: _____

If medication is needed at school, additional paperwork needs to be completed by **you and your child's doctor**.

Check here _____ if you need our office to send the appropriate forms home to you **or circle all that apply:**

My child has been: desensitized, no longer has a food allergy, medication is not required at school.

I will indemnify and hold St. Therese School and its employees harmless should any problems arise.

Parent's Signature: _____ Date: _____



Date: _____

To: Parents/Guardians

Re: 2026-2027 Food Allergy & Anaphylaxis Emergency Care Plan

Please review and sign the FARE (Food Allergy & Anaphylaxis Emergency Care Plan) form. Please complete the entire form, obtain required signatures, and return to your child's school. The FARE form addresses:

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

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:** _____

Physician Signature: _____ Date _____ Phone: _____

Parent/Guardian Signature: _____ Date _____ Phone: _____

Thank you

Name: _____ D.O.B.: _____

Allergic to: _____

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

 History of anaphylaxis: ☐ **Yes** ☐ **No**

**PLACE
PICTURE
HERE**

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

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.



- ADMINISTER EPINEPHRINE IMMEDIATELY.**
- 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.

ADDITIONAL PHYSICIAN COMMENTS

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 AND CALL 911.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine and call 911.

☐ If this box is checked by the child's physician, the child has an extremely severe allergy to _____ and should be given epinephrine at the first sign of any symptoms, even if mild.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

 Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

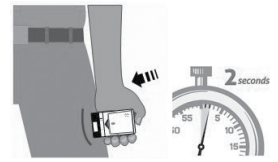
Antihistamine Dose: _____

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

☐ Patient may self-carry ☐ Patient may self-administer

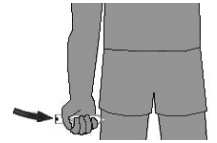
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



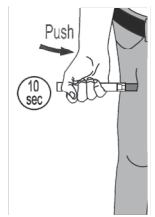
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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.



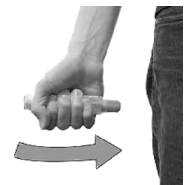
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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.



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.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



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: _____



2026-2027 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION
MAY NOT BE GIVEN AT SCHOOL.**

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

PARENT SIGNATURE/DATE

PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER

TELEPHONE NUMBER