Premier Children's Therapy Center
1000 Holcomb Woods Parkway Suite #422 Roswell, GA 30076
Phone: 770-641-8070 Fax: 770-641-8078

# PATIENT DATA FORM

PLEASE PRINT

**TODAY'S DATE:**

## PATIENT INFORMATION

| Child's Last Name: First: Middle: | Birth Date: | Age: | Sex: ☐ F ☐ M |
|---|---|---|---|
| Parent/Guardian Name: | | | |
| Street address: | City, State Zip Code: | | |
| Home Phone: | Mobile Phone: | Email: | |
| Physician (s): (If group, please provide practice name and name of primary physician) | | | |
| Physician's Address: | | | |
| Physician's Phone: | Physician's Fax: | | |
| Specialists: | | | |
| School Name and Grade: | | | |
| Referred By: | | | |

## PRIMARY INSURANCE INFORMATION

**(Please provide a photocopy back/front of your insurance card)**

| Primary Insurance Company: | | | Type (PPO, POS, HMO): |
|---|---|---|---|
| Primary Insured Name: | Birth Date: | Address (if different): | Home Phone: |
| Member Id: | Group: | Employer: | |
| Insurance Carrier's Mailing Address/Provider Service Phone # (From back of card) | | | |

## SECONDARY INSURANCE INFORMATION

**(Please provide a photocopy back/front of your insurance card)**

| Secondary Insurance Company: | | | Type (PPO, POS, HMO): |
|---|---|---|---|
| Primary Insured's Name: | Birth date: | Address (if different): | Home Phone: |
| Member Id: | Group: | Employer: | |
| Insurance Carrier's Mailing Address/Provider Service Phone # (From back of card) | | | |

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# HIPAA PRIVACY PRACTICES

The purpose of this notice is to ensure that you (the patient) or your designated representative are aware of your rights to ensure the privacy of your healthcare information. Premier Children's Therapy Center, Inc. retains the right to update this notice at any time. You may specify your designated contacts.

**Child's Name:** _____ **Date of Birth** _____

1. **Privacy of Patient Information:** We have created a record of the services and treatment received at Premier Children's Therapy Center. The privacy of your child's medical information is important to us and we are committed to protecting it. We are required by law to keep medical information private and notify you of legal rights and privacy practices.
2. **Use and Disclosure of Patient Information:** Your child's therapy information will be used for treatment, payment, and to communicate with other **healthcare professionals** (including your child's pediatrician), payers, state and federal entities, as well as law enforcement agencies in the interest of public safety, court/administrative order.
3. **Access to Medical Information:** You have the right to see and obtain a copy of your child's medical records at any time. If you request a copy of the information, we may charge a fee. Additionally, you may request changes to your health information, if you feel information is incorrect or incomplete. If Premier Children's Therapy Center, Inc. does not agree with your changes, you must be allowed to insert a statement of disagreement into the patient's record. Premier Children's Therapy Center, Inc. is not required to agree with your changes.
4. **Confidentiality of Patient Information:** Premier Children's Therapy Center, Inc. will attempt in all cases to preserve the confidentiality of all oral and written medical information. This includes patient records, written information, and electronic transmission of information to physicians, insurance companies, state and federal entities and law enforcement agencies in the interest of public safety. Premier Children's Therapy, Inc. will not be held responsible in the event of natural disasters, theft or burglary of their physical and electronic property having taken reasonable precaution.
5. **How to file a Complaint**: If you feel your privacy rights have been violated, please submit a complaint in writing to our Privacy Officer. There is no penalty for filing a complaint.
6. **Patient Personal Communication:** Premier Children's Therapy Center may communicate confidential information, *including photos or videos* of delivered services, insurance information, appointment reminders, evaluations, and documentation to designated caregivers below:

**PARENTS/GUARDIAN:**

Name/Relationship to Child_____

Mailing Address _____

Phone _____ Fax_____ Email _____

**ADDITIONAL CAREGIVER: (Nanny, Babysitter, Grandparent)**

Name/Relationship to Child _____

Mailing Address _____

Phone _____ Fax_____ Email _____

**OTHER PROFESSIONALS/SCHOOLS/SPECIALISTS**

Name (or title) and organization _____

Mailing Address _____

Phone _____ Fax_____ Email _____

7. **Premier Children's Therapy Center Contact Information:** You may contact the Practice Administrator at 770-851-9553.

Patient's or Designee's Signature _____ Date _____

Premier Children's Therapy Center

# CASE HISTORY FORM

(Please Print)

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Child's Name: | Age: | Grade: | Birth Date: | Sex: ☐ F ☐ M |
| Person Completing This Form: | Relationship To Child: | | Physician Name: | Physician Phone #: |

| BACKGROUND INFORMATION | | |
|---|---|---|
| Mother's Name: | Mother's Occupation: | Mother's Email Address: |
| Home Phone: | Cell Phone: | Work Phone: |
| Father's Name: | Father's Occupation: | Father's Email Address: |
| Home Phone: | Cell Phone: | Work Phone: |
| Street address: | City, State, Zip Code: | |
| Referred by: | | |
| Describe your child's home environment: (Please include sibling's names and ages and if living with caregivers (i.e. nanny, joint custody) | | |
| | | |
| Does anyone in your family have speech, developmental, neurological, or hearing problems? If yes, please explain: | | |
| | | |
| Describe your concerns regarding your child's development: | | |
| | | |
| Has there been a traumatic life event that your child has experienced? If yes, please describe: | | |
| | | |
| Has your child been referred by a professional? (Teacher, Physician, etc.) | | |
| Has your child been given a diagnosis? ☐ Yes ☐ No | What is the diagnosis? | |
| Does your child receive special services? If yes, please explain: | | |
| Has your child's vision been tested? If yes, by whom and when? Please explain the results of the test. | | |
| Has your child's hearing been tested? If yes, by whom and when? Please explain the results of the test. | | |
| Does your child wear any assistive devices? | | |
| ☐ Hearing Aids | ☐ Splints | ☐ Orthotic Inserts | ☐ Augmentive Communication Devices | ☐ Protective Head Gear |

## PRENATAL AND BIRTH HISTORY

| Length of pregnancy in weeks: | | | Birth Weight: |
|---|---|---|---|
| Full Term? | Breech? | One Minute APGAR: | Five Minute APGAR: |

Prenatal Care Included:

Were there any complications during the pregnancy or birth? If Yes, please explain:

Type Of Delivery: ☐ Induced ☐ Vaginal ☐ Cesarean ☐ Vacuum Extraction ☐ Forceps

Please explain:

Were there any problems or complications immediately following the birth or during the first few weeks of your infant's life?

☐ Jaundice ☐ Feeding ☐ Swallowing ☐ Hospitalizations ☐ Seizures ☐ Other

Please explain:

How long was the infant's stay in the hospital following birth? _____

Did your child come home from the hospital with you? ☐ Yes ☐ No

Breast Fed? ☐ Yes ☐ No How Long? _____

Bottle Fed? ☐ Yes ☐ No How Long? _____

Pacifier? ☐ Yes ☐ No How Long? _____

## DEVELOPMENTAL HISTORY

At what age did the following **developmental milestones** occur?

| | | |
|---|---|---|
| _____ Held head up | _____Followed objects with eyes | _____ Rolled over from back to stomach |
| _____ Sat up unsupported | _____Crawled | _____ Stood alone |
| _____ Walked alone | _____Fed self with spoon | _____ Dressed self |
| _____ Toilet trained | _____Used fork | |

At what age did the following **speech/language milestones** occur?

| | | |
|---|---|---|
| _____ Babbled or cooed | _____Said first word | _____ Begin to use two- word phrases |
| _____ Begin to use sentences | _____Follow simple directions | _____ Pointed to objects |

How does your child express him/her self? (Please circle one)

☐ Sentences ☐ Phrases ☐ One or two-words ☐ Sounds ☐ Gestures Other: _____

How many words are in your child's vocabulary? _____

Does your child have any feeding/swallowing issues? If yes, please explain:

What types of foods does your child prefer?

What type of food does your child refuse?

Please list any medications or supplements that your child is currently taking:

Does your child have any food allergies or follow a special diet? If yes, please explain:

## MEDICAL HISTORY

Check any of the following conditions or surgeries that your child has experienced. Please specify age and condition status for each:

| CONDITION | YES | NO | AGE | SURGICAL INTERVENTION | DATE(S) | CHRONIC (C) RESOLVED (R) |
|---|---|---|---|---|---|---|
| Adenoidectomy | ☐ | ☐ | | | | |
| Allergies | ☐ | ☐ | | | | |
| Asthma | ☐ | ☐ | | | | |
| Balance/Falling Problems | ☐ | ☐ | | | | |
| Chicken Pox | ☐ | ☐ | | | | |
| Chronic Colds | ☐ | ☐ | | | | |
| Croup | ☐ | ☐ | | | | |
| Diphtheria | ☐ | ☐ | | | | |
| Dysphasia | ☐ | ☐ | | | | |
| Ear Infections | ☐ | ☐ | | | | |
| Encephalitis | ☐ | ☐ | | | | |
| Epilepsy | ☐ | ☐ | | | | |
| Feeding Mismanagement | ☐ | ☐ | | | | |
| Fractures | ☐ | ☐ | | | | |
| Frenulectomy | ☐ | ☐ | | | | |
| GE Reflux (GERD) | ☐ | ☐ | | | | |
| Head Injuries | ☐ | ☐ | | | | |
| Headaches | ☐ | ☐ | | | | |
| Influenza | ☐ | ☐ | | | | |
| Mastoidectomy | ☐ | ☐ | | | | |
| Measles | ☐ | ☐ | | | | |
| Meningitis | ☐ | ☐ | | | | |
| Mumps | ☐ | ☐ | | | | |
| PE Tube Insertion | ☐ | ☐ | | | | |
| Pneumonia | ☐ | ☐ | | | | |
| Scarlet Fever | ☐ | ☐ | | | | |
| Tonsillectomy | ☐ | ☐ | | | | |
| Tonsillitis | ☐ | ☐ | | | | |
| Typhoid | ☐ | ☐ | | | | |
| Whooping Cough | ☐ | ☐ | | | | |
| Other | ☐ | ☐ | | | | |

Describe any major accidents, surgeries, or hospitalizations your child has had (i.e., car accidents, falls, crash injuries, etc):

## EDUCATIONAL HISTORY

| Does your child attend: | ☐ Day Care | ☐ Preschool | ☐ Elem/Mid School | ☐ Other: |
|---|---|---|---|---|

Name of School:

Address:

City, State, Zip

Number of days per week in school?

Does your child have a current IEP/IFSP? ☐ Yes ☐ No
**If Yes, please provide a copy to your therapist on or before your first visit.**

Is your child currently experiencing difficulties at school or daycare? If yes, please describe:

**Educational, Psycho/Neuro Psychiatric Assessments:**
Has your child ever had a full battery of tests done by a psychologist or psychiatrist?

If so, please name testing professional:

What types of tests were done?

What were the Results?

What is most important to you that we work on with your child?

## CURRENT FUNCTIONING

On a scale of 1 to 4 how well does your child function in the following areas? (Circle One) Depending on the age of your child, it may be completely appropriate for them to be dependent in many areas of functioning.

1 = Completely dependent on others. Needs lots of help or cues.

2 = Requires adult assistance for 50% of the tasks or 50% of the time.

3 = Requires very little, but some adult assistance.

4 = Completely independent. No difficulties in this area.

| | | | | | |
|---|---|---|---|---|---|
| Dressing upper body | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Taking off clothing | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Putting on shoes/socks | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Putting on pants | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Eating (breast or bottle) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Eating (soft foods off spoon) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Eating (with fingers) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Eating (with utensils) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Playing with familiar peers | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Playing with unfamiliar peers | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Handwriting | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Frustration tolerance | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Sleeping Routine | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Grooming (hair) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Grooming (bathing) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Grooming (teeth) | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Maintaining attention to tasks | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Entertaining self | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Hand/eye coordination | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Balance | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Following verbal directions | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Safety Awareness | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |
| Cutting with scissors | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ Not Applicable |

| | |
|---|---|
| Please list your child's strengths: | |
| Please list your child's weaknesses: | |
| What are your goals for therapy? | |
| Please let us know your child's favorite things: | |
| Food: | Snack: |
| Drink: | Candy: |
| Toy: | Game: |
| Activities: | TV Show/Movie: |
| Other Favorites: | |
| | |
| **Please use the rest of this page or attach any additional pages you need to share other information that will help us to understand your child and family:** | |
| | |

Please be sure to include copies of the following documents (if applicable): Having these documents will assist your therapist in complete their assessment and getting a complete picture of your child.

- ☐ Current or most recent IEP/IFSP
- ☐ Prior Speech, Physical or Occupational Therapy Evaluations
- ☐ Prior Psychological/Neurological Evaluations

08-2014

Date Completed: _____

Save Form

Print Form

Reset Form

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# OFFICE POLICIES

Please read and initial the information listed below:

Patient Name: _____ Date: _____

***PLEASE READ CAREFULLY***

_____1) **CANCELLATION/NO SHOW POLICY:** Cancellations must be reported **directly to your therapist (or therapists if your child sees multiple therapists)**. Acceptable communication methods are email or text message. Notification must be at **least 24 hours prior to your scheduled visit**. Cancellations or no shows will be assessed a $50 fee, $75 if the scheduled visit falls during nationally observed holiday weeks. This policy will be strictly enforced. Calls to anyone other than the treating therapist are not acceptable. Please ensure that you have your therapist's contact information! Cancellation fees are NOT covered by insurance. In the event of illness, hospitalization or critical care situation, this fee may be waived at the discretion of the clinic director only.

_____2) **ATTENDANCE POLICY:** Therapy visits are reserved especially for your child and their therapist each week. Regular excused or unexcused absences and tardiness that exceeds 20% of the monthly scheduled visits will result in a forfeiture of that therapy slot.

_____3) **EXTENDED TIME:** Extended time with your therapist, after therapy sessions, cannot be accommodated to allow your therapist to attend to her next patient. Additionally, consultation fees may be assessed for extensive phone, email and/or texting with your therapist.

_____4) **INSURANCE INFORMATION:** Premier is happy to contact your insurance carrier to verify your coverage, deductibles, co-pays, policy limits and pre-certification requirements. **Verification of coverage is NOT a guarantee of payment.** Many plans have coverage exclusions for therapy services that are missed, misunderstood or misinterpreted by insurance representatives. You are ultimately responsible for any and all charges incurred from treatment provided, despite conflicting or inaccurate information received from your carrier during the verification process. We request that you contact your Member Services department to verify the information we provide to you.

_____5) **VISIT LIMITS:** Most insurance plans have a defined visit limit for therapy. Many limits are combined with other therapies and therapy received at other facilities. **Patients are responsible for understanding their policy limits and tracking the number of visits incurred.** If your child has a therapy visit beyond the plans limits, you are responsible for the full cost of that visit.

_____ _____

Parent/Legal Guardian Relationship to Child

_____

Date

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## CONSENT FOR PAYMENT AND FINANCIAL RESPONSIBILITY

_____1) **Assignment of Benefits:** Premier Children's Therapy Center, Inc is authorized to bill my insurance carrier for direct reimbursement of therapy services rendered to my child. Benefit payment will be assigned directly to Premier Children's Therapy Center. Premier may release only medical information that is needed to determine the benefits payable for related services. Any remaining amount owed for services that are partially covered or not covered are my responsibility.

_____2) **Patient Financial Responsibility:** I will be responsible for the cost of all services. Charges may be the result of deductibles, co-pays, co-insurance and all non-covered procedures or treatment codes regardless of in network or out of network status. Depending on your policy, your insurance company will pay all, part or none of the cost of therapy evaluations and visits. You are ultimately responsible for any and all charges for services received by Premier, regardless of whether your insurance carrier should or should not have paid covered the services.

Patients without therapy benefits will be required to pay at the time of service or can prepay for services. Premier's Alternative Payment options are available on our fee schedule for not covered charges, out of network patients or high deductible plans.

_____3) **Offsite Therapy:** There is an additional $10 travel fee for offsite therapy, including homes, day care centers, preschools and elementary schools. Travel fees are not covered by medical insurance plans. Note, this is an increased rate for 2017!

_____4) **Billing Insurance:** With this authorization, Premier will file claims to my carrier on our behalf. If charges billed are not paid timely, Premier will make (2) two attempts to resolve the issues. After (2) two attempts, I am responsible to pay the charges and resolve the issue with my insurance company. Premier will be happy to reimburse once payment has been received from the insurance company.

_____5) **Insurance Payments:** If payment from insurance is paid directly to me for services billed by Premier, the full payment amount received by the insurance carrier must be remitted to Premier either via a reassigned check or direct payment from me.

_____6) **Billing Invoices:** Each of your child's visits is documented by their therapist and reviewed by the clinic director before we submit a claim to your insurance company. Additionally, insurance companies may take 4-6 weeks to make payments. After receiving an EOB and/or payment from the carrier, any remaining balance due will be billed monthly. As a result, you may not receive a billing statement until 6-8+ weeks after a visit. We will give you an estimate of your expected rate per visit. Please be aware of this *estimate* to avoid a surprise when the invoice arrives with multiple dates of service at a time.

_____7) **Outstanding Balances**: Balances are due within 15 business days of receipt of your invoice unless prior arrangements are made. We accept checks or the following credit cards: MasterCard, Visa, or American Express. Accounts which are consistently delinquent will be required to settle monthly statements via credit card. Payments are considered delinquent 30 days after the invoice date unless prior arrangements are made in advance. Delinquent accounts will be subject to outside collections.

_____8) **Insurance Changes:** I understand that I am responsible for notifying Premier of any changes with my insurance carrier and/or personal data **prior to the start date of the new coverage**. New coverage may require a referral, precertification or other authorization which may necessitate a period of self-pay or break in therapy services. Additionally, new coverage may be subject to different rates and restrictions and exclusions.

I have read the above and agree to be financially responsible for prompt payment and to timely provide all current insurance information.

_____ _____
Parent/Legal Guardian Relationship to Child

_____ _____
Date Therapist/Witness

Save Form

Print Form

Reset Form

Premier Children's Therapy Center
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Clinic: 770.641.8070 Fax: 770.641.8078

| CREDIT/DEBIT CARD INFORMATION | |
|---|---|
| **PATIENT NAME(S):** | |
| **CARD TYPE:** | |
| **NAME ON CARD:** | |
| **BILLING ADDRESS:** | |
| **CARD NUMBER:** | |
| **EXPIRATION DATE:** | |
| **SECURITY CODE:** 4 Digit –AMEX, 3 Digits- ALL others | |
| **Is this an FSA or HSA Card?** | ❑ Yes ❑ No |

Choose One:

O I wish to have monthly statements and approve each credit/debit card charge.

O I agree to have my credit/debit card automatically charged for regular co-pay's, co-insurance, deductibles and services not covered by my insurance.

Charges will be made by encrypted internet only. This information will be kept in a secure off limit location and will not be kept at the clinic.

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# ADVANCED BENEFICIARY NOTICE

PATIENT NAME: _____ DATE OF BIRTH: _____

This notice applies to all insurance carriers, regardless of network status.

The purpose of this form is to advise you of the fees associated with an Occupational, Physical or Speech Therapy evaluation. It is important for you to know that if your therapist recommends an evaluation for your child, you may have to pay a portion or all of the evaluation cost. Please read this entire notice carefully.

Your insurance company may or may not pay in full for an Occupational, Physical or Speech Therapy evaluation. Many insurance plans do not always consider all health care costs as a covered benefit. Your insurance company follows the coverage rules as defined by your plan documents.

Therapy Evaluations involve multiple components including, but not limited to the following items.

- Review of case history, medical history, prior evaluations and reports
- Consultation with parents, teachers, specialists or other therapists (only with proper consents)
- Administering standardized tests, clinical observations
- Collecting results and documentation
- Entering test data into proprietary software to obtain results
- Review and analyze all collected information and prepare a detailed written report.

I understand that if my child requires a therapy evaluation, I may be responsible for all non-covered and non-allowable charges, co-insurance, co-pays and any amounts applied to my deductible. I understand that my Insurance Company may not cover the entire cost of the evaluation services. If my insurance company denies payment, or partially pays, I agree to be personally and fully responsible for payment.

_____ _____
Parent/Legal Guardian Relationship to Child

_____
Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

# 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 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.

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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person 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: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

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

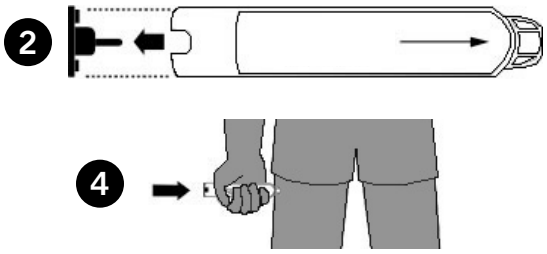
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

# FARE Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

## EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.




## ADRENACLICK®/ADRENACLICK® GENERIC 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 penetrates.
5. Hold for 10 seconds. Remove from thigh.


**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 get worse quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

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