

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
ALLERGY ACTION PLAN

PROCEDURE ON REVERSE

PART I TO BE COMPLETED BY PARENT

Student _____ D.O.B _____ School _____

ALLERGY _____ Teacher/Grade _____

Emergency Contacts:

Name/Relationship

Phone Number(s)

_____ 1.) _____ 2.) _____

_____ 1.) _____ 2.) _____

Asthmatic " Yes* " No *High risk for severe reaction

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

TREATMENT PLAN FOR ALLERGY



For medications administered during school, complete required EpiPen/Medication Authorization forms.

Symptoms:

Give Checked Medication:

- | | | |
|--|-------------|---------------|
| • If a food allergen has been ingested, but <i>no symptoms</i> : | Epinephrine | Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth | Epinephrine | Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities | Epinephrine | Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea | Epinephrine | Antihistamine |
| • Throat* Tightening of throat, hoarseness, hacking cough | Epinephrine | Antihistamine |
| • Lung* Shortness of breath, repetitive coughing, wheezing | Epinephrine | Antihistamine |
| • Heart* Thready pulse, low blood pressure, fainting, pale, blueness | Epinephrine | Antihistamine |
| • Other* _____ | Epinephrine | Antihistamine |
| • If reaction is progressing (several of the above areas affected), give | Epinephrine | Antihistamine |

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

PLACE EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

Licensed Health Care Provider (Print) Licensed Health Care Provider (Signature) Telephone Date

I approve of this Allergy Action Plan, I give permission for school personnel to perform and carry out the tasks as outlined. I consent to the release of the information contained in this management plan to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent / Guardian Signature Telephone Date

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PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Student _____ School _____ Teacher/Grade _____

Parent/Caregiver _____ Phone (H) _____ (W) _____ (C) _____

ALLERGY _____


ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- | | | | |
|---|-----|----|-------|
| • Allergy Action Plan Part I and II, complete | yes | no | |
| • Medication authorization complete | yes | no | n/a |
| • EpiPen authorization complete | yes | no | n/a |
| • Medication maintained in school designated area | yes | no | |
| • Medication self carried | yes | no | |
| • Expiration date of medication(s) | | | _____ |
| | | | _____ |
| • Staff trained in medication administration | yes | no | |
| • Copies of plan provided to: | | | |
| Educational | yes | no | n/a |
| Athletic | yes | no | n/a |
| After school | yes | no | n/a |
| Food service | yes | no | n/a |

Trained staff

Name	Date	Location
Name	Date	Location
Name	Date	Location
Name	Date	Location

The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.



Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds**
- Remove EpiPen, call 911 for immediate follow up and send the pen with the caregiver to the emergency room.
- Use care with exposed needle. Destroy needle by placing a penny into empty tube and inserting spent pen. New packaging allows inserting the pen without a penny.

Full Allergy Action plan has been implemented.

Principal or Registered Nurse

Date