

**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
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ALLERGY	Teacher/Grade
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Emergency Contacts:

Name/Relationship	Phone Number(s)
	1.)
	2.)
	1.)
	2.)

Asthmatic Yes* No *Higher risk for severe reaction

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

TREATMENT PLAN FOR ABOVE ALLERGY

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

Symptoms: **Give Checked Medication:**

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

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

DOSAGE

Epinephrine: inject intramuscularly (mark 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	<input type="checkbox"/> yes	<input type="checkbox"/> no	
• Medication authorization complete	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
• EpiPen authorization complete	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
• Medication maintained in school designated area	<input type="checkbox"/> yes	<input type="checkbox"/> no	
• Medication self carried	<input type="checkbox"/> yes	<input type="checkbox"/> no	
• Expiration date of medication(s)			
• Staff trained in medication administration	<input type="checkbox"/> yes	<input type="checkbox"/> no	
• Copies of plan provided to:			
Educational	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
Athletic	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
After school	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> n/a
Food service	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> 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 _____