

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON

ALLERGY ACTION PLAN

FOR USE WITH EPINEPHRINE ADMINISTRATION AUTHORIZATION AND ANTIHISTAMINE AUTHORIZATION FORMS

PROCEDURE ON REVERSE

PART I TO BE COMPLETED BY PARENT

STUDENT _____ Date of Birth _____ School _____

ALLERGY _____ Teacher/Grade _____

ROUTE OF EXPOSURE--- CONTACT INGESTION INHALATION STING

Parent / 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 and school- sanctioned activities, complete and attach the required Office of Catholic Schools Diocese of Arlington, Epinephrine and Antihistamine Authorization forms.

If prescriber is ordering Epinephrine and antihistamine, Epinephrine will be administered FIRST unless otherwise prescribed by the health care provider.

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.

PLACE EMERGENCY CALLS

- Call 911 Immediately. State an allergic reaction has occurred.**
- Notify prescriber of epinephrine use and allergic reaction.**

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 _____ Date of Birth _____ Teacher/Grade _____

CAUTION

Administration of an oral antihistamine should be considered only if the student's airway is clear and there is minimal risk of choking.

ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- | | | | |
|---|-----|----|--------------|
| • Allergy Action Plan Parts I and II, complete | yes | no | |
| • Antihistamine authorization complete | yes | no | n/a |
| • Epinephrine 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 |
| | | | Food service |
| | | | yes no n/a |

Staff trained in epinephrine and antihistamine administration

Name	Date	Location
Name	Date	Location
Name	Date	Location

NOTES

Full Allergy Action plan has been implemented.

Principal or Registered Nurse _____ Date _____