CSO/15-H2

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
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** ***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 *no symptoms*:		☐ 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** After school **yes** **no** **n/a**
  Athletic **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