OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON CSO/15-H2

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

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
ALLERGY ACTION PLAN
PAGE 2

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