

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

*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/Twinject/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. Twinject

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

Adapted from: Virginia Department of Health, Virginia Department of Education. (2004) Guidelines for Specialized Health Care Procedures

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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 parts I and II, complete yes no
- Medication 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	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

Full Allergy Action plan has been implemented.

Principal or Registered Nurse _____ Date _____