

**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> :                          | 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.

**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	After school	yes	no	n/a
Athletic	yes	no	n/a.	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