Diocese of Arlington Catholic Schools
Allergy Action Plan

For Use with Epinephrine Administration Authorization and Antihistamine Authorization Forms

Name: _____D.O.B: _____/_____/_____

Allergy to: _____

Weight: _____lbs. Asthma: ___Yes (higher risk for severe reaction) ___No Grade: _____

Place Student's Picture Here

Extremely reactive to the following food: _____
THEREFORE:
___ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

___ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing / swallowing
MOUTH:	Obstructive swelling (tongue and / or lips)
SKIN:	Many hives over body

Or combination of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT:	Vomiting, diarrhea, cramping pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. **Call 911**
3. **Begin monitoring (see box below)**
4. **Give additional medications:***
   - Antihistamine
   - Inhaler (bronchodilator) if Asthma

* Antihistamines & inhalers / bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth / face, mild itch
GUT:	Mild nausea / discomfort

1. **GIVE ANTIHISTAMINE**
2. **Stay with student: alert Healthcare professionals first, then parent**
3. **If symptoms progress (see above), USE EPINEPHRINE**
4. **Begin monitoring**

Medications / Doses
Epinephrine (brand and dose): _____

Antihistamine (brand and dose: _____
A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.

It is my professional opinion that this student SHOULD / SHOULD NOT carry his / her epinephrine auto-injector.

_____ _____ _____ _____
Parent / Guardian Signature **Date** **Physician / Healthcare Provider Signature** **Date**

Parent signature gives permission for principal's designee to follow this plan, administer prescribed medicine, and contact physician, if necessary.

_____ _____ _____
Physician's Printed Name / Address **Fax Number** **Phone Number**

Monitoring

Stay with student; alert healthcare professionals and then the parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note the time when epinephrine was administered. For severe reaction, consider keeping student lying on back with legs raised. Treat student if parents cannot be reached.
DO NOT MOVE STUDENT.

3-Step Easy to Follow Instructions:

1. **Prepare** the Auto-Injector Injection
2. **Administer** the Auto-Injector
3. **Finalize** the Injection Process

Contacts

Doctor: _____ Phone (_____) _____ - _____

Parents / Guardian: _____ Phone (_____) _____ - _____

Other Emergency Contacts

Name / Relationship: _____ Phone (_____) _____ - _____

Name / Relationship: _____ Phone (_____) _____ - _____

Number of epinephrine auto-injectors received: 1____ 2____ 3____4 ____ Expiration Date: _____

Signature of Clinic Staff / Date: _____

Number of epinephrine auto-injectors returned: 1____ 2____ 3____4 ____

Signature of Parent / Date: _____