OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON

SEVERE ALLERGY/ANAPHYLAXIS ACTION PLAN & TREATMENT AUTHORIZATION

Appendix F-4

PART I - TO BE COMPLETED BY PARENT

Student ______________________ Date of Birth__________ Teacher/Grade______________

Allergy ______________________

Weight ____________lbs. Route of Exposure Contact Ingestion Inhalation Sting

Asthmatic Yes* No *Higher risk for severe reaction Parent / Guardian Initials ______________

PART II - TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

If checked, give epinephrine immediately for **ANY** symptoms if the allergen was likely eaten / contacted.

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

FOR **ANY** OF THE FOLLOWING: **SEVERE SYMPTOMS**

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 or swallowing
MOUTH	Obstructive swelling (tongue or lips)
SKIN	Many hives over body

Or combination of symptoms from different body areas

SKIN	Hives, itchy rashes, swelling
GUT	Vomiting, cramps, pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications if applicable
   a. Antihistamines
   b. Inhaler

Antihistamines and Inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHRINE

MILD SYMPTOMS ONLY

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

1. **GIVE ANTIHISTAMINE** if ordered
2. Stay with student, alert parent
3. If symptoms progress see above
4. Begin monitoring

MEDICATIONS / DOSES:

Epinephrine Auto-Injector (brand and dose): ________________________________

Antihistamine (brand and dose): ________________________________

(Antihistamines should NOT be used as a first line of treatment during an anaphylaxis episode. It will treat itching ONLY-it will not halt vascular collapse or swelling!)

Other (e.g., Inhaler-bronchodilator if wheezing)________________________________

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

______________________ ______________________ ____________ ____________

Licensed Health Care Provider (Print) Licensed Health Care Provider (Signature) Telephone Date

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON

SEVERE ALLERGY/ANAPHYLAXIS ACTION PLAN & TREATMENT AUTHORIZATION

PART III - PARENT SIGNATURE REQUIRED

Student______________________________ Date of Birth ____________ Teacher/Grade____________

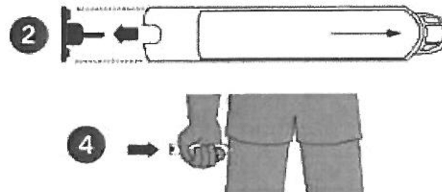
Administration of an oral antihistamine should be considered only if the student's airway is clear and there is minimal risk of choking.

MONITORING

Stay with student, Call 911 and parent. Tell 911 epinephrine was given, request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given within 15 minutes, after the first, if symptoms persist or recur. Place student in rescue position. Treat student even if parents cannot be reached.

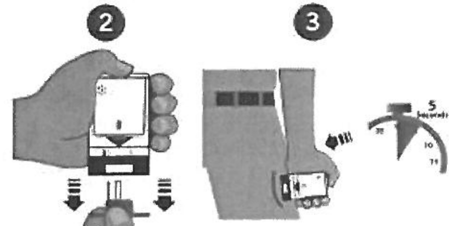
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this action plan and treatment authorization. A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS:

Name/Relationship: ______________________________ Phone:____________________
Name/Relationship: ______________________________ Phone:____________________
Name/Relationship: ______________________________ Phone:____________________

I hereby authorize for school personnel to take whatever action in their judgment may be necessary in providing emergency medical treatment consistent with this plan, including the administration of medication to my child. I understand the Virginia School Health Guidelines, Code of Virginia, 8.01-225 protects school staff members from liability arising from actions consistent with this plan.

______________________________ ________________ ____________
Parent / Guardian Signature Telephone Date