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

Form adapted compliments of FARE www.foodallergy.org

Revised 2015

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SEVERE ALLERGY/ANAPHYLAXIS ACTION PLAN & TREATMENT AUTHORIZATION

PART III - PARENT SIGNATURE REQUIRED

Student_____ Date of Birth _____Teacher/Grade_____

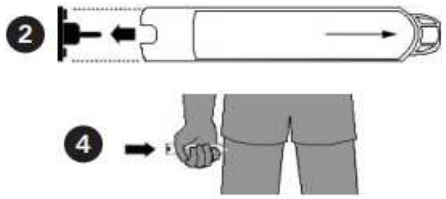
Administration of an oral antihistamine should be considered only if the student's airway is clear and there is minimal risk of choking.

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.

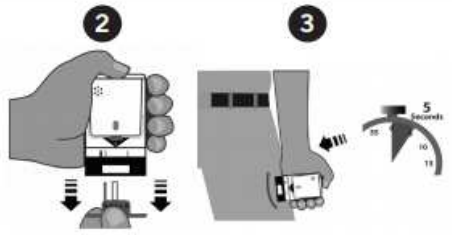
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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

F-4

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
EPINEPHRINE AUTHORIZATION
FOR USE WITH ANTIHISTAMINE AUTHORIZATION AND ALLERGY ACTION PLAN

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for administering this injection, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures outlined on the back of this form and assume responsibility as required

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances

_____ _____ _____

Parent or Guardian Signature | Daytime Telephone | Date

PART Il TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS.

Emergency epinephrine injections may be administered by trained non-health professionals. These persons are prepared by licensed health care personnel to administer the injection. For this reason, only pre-measured doses of epinephrine (auto injector) may be given.

After report of student exposure to _____, via (route of exposure) □ Ingestion □ Skin contact □ Inhalation □ Insect bite or sting
the following action will be taken; (specific allergens)

† The following injectable epinephrine dosage will be given immediately, as prescribed below.
† The following injectable epinephrine dosage will be given as noted below and as detailed on the attached Allergy Action Plan (F-4A),in conjunction with the Antihistamine Authorization Form (F-4B)

Check ✓ appropriate boxes:

† EpiPen 0.3 † Twinject 0.3 † Adrenaclick 0.3 Auvi-Q 0.3

□ Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh.

□ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

† EpiPen Jr. 0.15 † Twinject 0.15 † Adrenaclick 0.15 Auvi-Q 0.15

□ Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3 cc) by auto injection, intramuscularly in anterolateral thigh.

□ Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

COMMON SIDE EFFECTS

EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which medications are to be taken

Check ✓ appropriate box:

□ I believe that this student has received adequate information on how and when to use an epinephrine auto injector, and has demonstrated its proper use.

a. The student is to carry an auto injector during school hours with principal approval. The student can use the auto injector properly in an emergency.

b. One additional dose, to be used as backup, should be kept in clinic or other school location.

□ The auto injector will be kept in the school clinic or other school approved location _____.

_____ _____ _____ _____

Licensed Health Care Provider (Print or Type) | Licensed Health Care Provider (Signature) | Telephone or Fax | Date

_____ _____ _____ _____

Parent or Guardian (Print or Type) | Parent or Guardian Signature | Telephone | Date

_____ _____

Student Signature (Required if student carries Auto injector) | Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

□ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

□ Auto injector is appropriately labeled. _____ Date by which any unused Auto injectors are to be collected by the parent (within one week after expiration of the physician order or on the last day of school).

I have reviewed the proper use of an Auto Injector with the student and, † agree † disagree that student should self carry in school.

_____ _____

Signature Date

Revised 2013

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (e.g. inhaler, autoinjector). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order

10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.

13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, auto injector)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

Revised 2013