

LACORDAIRE ACADEMY
Life Threatening Allergy Action Plan

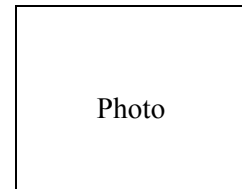
Part 1: To be completed by Physician

Student's Name: _____ D.O.B. _____ Grade: _____

ALLERGY TO: _____

Medical Diagnosis and code: _____

Asthmatic Yes * No (*Higher risk for severe reaction)



STEP 1: TREATMENT

Symptoms:

- * If a food allergen has been ingested, but *no symptoms*:
- * Mouth: Itching, tingling, or swelling of lips, tongue, mouth
- * Skin: Hives, itchy rash, swelling of the face or extremities
- * Gut: Nausea, abdominal cramps, vomiting, diarrhea
- * Throat ^-- Tightening of throat, hoarseness, hacking cough
- * Lung ^-- Shortness of breath, repetitive coughing, wheezing
- * Heart ^-- Thready pulse, low blood pressure, fainting, pale, blueness
- * Other _____

Give Checked Medication

___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine
___ Epinephrine	___ Antihistamine

* If reaction is progressing (several of the above areas affected), give _____ Epinephrine ___ Antihistamine
The severity of symptoms can quickly change. ^Potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly (circle one):

Epi-pen Epi-Pen Jr Twinject TM 0.3 mg Twinject TM 0.15 mg.

Antihistamine: give _____
Medication/dose/route

Check all that apply:

- _____ Student has been trained in procedure and may carry and self-administer Epi-Pen
- _____ Student has been instructed in symptom recognition, is capable of, and may self-administer Benadryl according to N.J.S.A. 18A:40-12.3
- _____ Student may self-administer (circle one) with or without adult supervision.
- _____ Benadryl may be omitted from the above plan on a field trip in the absence of an authorized Licensed staff member and when student is not capable of self administering this. (Parent has option of accompanying child and administering this on field trip)

STEP 2: EMERGENCY CALLS

1. Call 911 (requesting paramedics). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Call Emergency contacts as listed on reverse side.

If Parent/Caregiver cannot be reached, do not hesitate to medicate or take child to medical facility.

Parent/Caregiver Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Physician Stamp: _____

LACORDAIRE ACADEMY

PART 2: To be completed by Parent/Caregiver

Emergency Contacts:

Name/Relationship Phone Number(s):

a. _____	1. _____	2. _____
b. _____	1. _____	2. _____
c. _____	1. _____	2. _____

A. Parent/Caregiver Permission for School Nurse Administration of Medication

To be completed by Parent/Caregiver: I give my permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of Lacordaire Academy as it concerns the use of this medication.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the school.

Parent/Caregiver Signature

Date

B. Parent/Caregiver Permission for Self-Administration of Epi-Pen and/or Benadryl

To be completed by Parent/Caregiver: I give my permission for my child to self-administer the medication **as described on the reverse side**. I will notify the school nurse immediately if this medication is no longer directed by the physician.

I understand and agree that the school shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the self administration of medication by the pupil.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the school.

Parent/Caregiver Signature

Date

C. Student Agreement for Self-Administration

To be completed by the student: I understand that I will use this medication as directed by my physician. I will be responsible and discreet using the medication as described on the reverse side and should have this medication readily accessible. I have been instructed how to self-administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container.

I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-administer this medication. I disclaim all liability of Lacordaire Academy as it concerns my use of this medication.

Student's Signature

Date