FORM 6

ALLERGY AGREEMENT AND ACTION PLAN

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Student's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Name Male Female *mm/dd/yyyy*

Allergies: _____

Weight: _____ Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

Teacher's Name: _____ Grade: _____

PART I: To be completed and signed by Parent/Guardian and Physician/LHCP

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

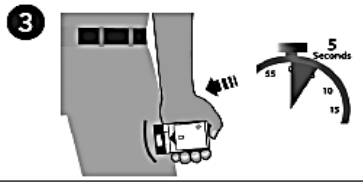
_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

ARCHDIOCESE OF WASHINGTON
Rev. August 2017

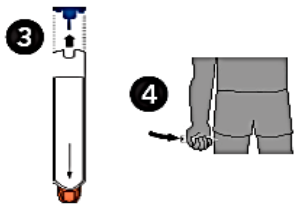
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



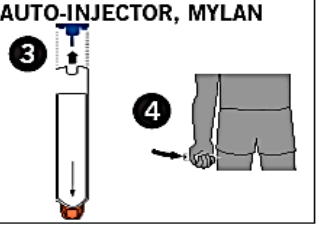
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



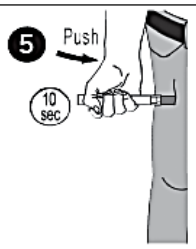
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

For completion by the student's physician/HCP:

Check ONE of the two boxes below:

☐ I recommend that the school permit the student to carry and, if necessary, self-administer the auto injector. I believe that this student has received adequate information on how and when to use Auto injector, has demonstrated its proper use, and has the capacity to use the injector in an emergency.

a. The student is to carry an auto injector during school hours with principal and/or nurse approval.
b. The student can use the auto injector properly in an emergency
c. One additional dose, to be used as backup, should be kept in clinic or other designated location in the school.

☐ I recommend that the auto injector be kept in the school clinic or other school-approved location.

Licensed Healthcare Provider: _____ Phone: ( ) -

Signature of LHCP: _____ Date _____

EMERGENCY CONTACT INFORMATION

Mother/Guardian Name: _____ Phone: ( ) -

Father/Guardian Name: _____ Phone: ( ) -

OTHER #1 Name: _____ Phone: ( ) -

OTHER #2 Name: _____ Phone: ( ) -

PART II: Information about Medication Procedures
Parent/Guardian Consent & Permission for Emergency Treatment

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined herein, in the Archdiocese of Washington Catholic Schools Policies, and district, state, and/or professional guidelines.

2. **Schools do NOT provide medications for student use. The student's parent/guardian is responsible for providing the school with any medication the student needs, and for removing any expired or unnecessary medication for the student from the school.**

3. Medication must be kept in the school health office or other location approved by the principal during the school day. All medication in the school's possession will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, except in the case of the student being authorized to self-carry certain medication (e.g., inhaler or Epi-pen). For such a case, the school recommends that the parent/guardian provide the school with a backup medication to be kept by the school.

4. All prescription medications, including physicians' samples, must be in their original containers and labeled by a licensed health-care professional (LHCP) or pharmacist, and must not have passed its expiration date. Within one week after the expiration of the LHCP's order for the medication, or on the last day of school, the parent/guardian must personally collect any unused portion of the medication. Medications not so claimed will be destroyed.

5. The student's parent/guardian is responsible for submitting a new Allergy Agreement and Action Plan to the school at the start of the school year and each time there is a change in the dosage or the time or method of medication administration.

6. In the event the parent/guardian named below cannot be contacted, I, the undersigned parent/guardian, do hereby authorize Archbishop Neale School to obtain emergency medical treatment for the health of my child, _____. I will not hold Archbishop Neale School responsible for the emergency care and/or emergency transportation for the said student.

7. I approve of this Allergy Action Plan, and I give permission for school personnel to perform and carry out the tasks as outlined above. I consent to the release of the information contained in this 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.

8. **I hereby request designated** Archbishop Neale School **personnel to administer medication, including epinephrine, as directed by this authorization. I agree to release, indemnify, and hold harmless the Archdiocese of Washington and its parish and/or school personnel, employees, and agents from any lawsuit, claim, expense, demand or action, etc., against them relating to or arising out of the administration of this medication. I have read the procedures outlined above and assume responsibility as required. I am aware that the medication may be administered by someone who is not a health professional.**

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date** _____

Signature of Student **(Required for student to carry auto injector)**: _____

PART III: Agreement, Release and Wavier of Liability

This AGREEMENT, RELEASE AND WAIVER OF LIABILITY (hereinafter referred to as "Release") is made by and between

Archbishop Neale School **,** a Roman Catholic elementary school of the Archdiocese of Washington ("the School") and _____ , ("Parents") parents of _____ ("Student").
Parent/Guardian's Name *Student's Name*

1. We the undersigned parents/guardians of the above Student request that the School enroll our child, who has allergies, for the current _____ school year. We request that the School work with us to develop a plan to accommodate the Student's needs during school hours.

2. The parties understand, acknowledge and agree that it is beyond the School's ability to guarantee an allergen-free environment.

3. The parties understand, acknowledge and agree that it is beyond the School's ability to monitor or supervise Student's compliance with personal food restrictions or other restrictions and that the School will not do so.

4. The parties understand, acknowledge and agree that it is beyond the School's ability and resources to prevent contamination of Student's food and to provide allergen free surfaces on all desks and tables where Student may be seated.

5. The parties understand and acknowledge that the School does not have a full-time nurse or any other medical professional on staff.

6. We have provided the School with an Allergy Action Plan which was completed by Student's physician. It includes parental permission, authorizing School personnel to assist in the administration of that Allergy Action Plan, in the form attached hereto as Exhibit A, which is subject to the School's review and acceptance.

7. We have executed and submitted a Medical Information Form and Permission for Emergency Treatment for Student, which is included in the Allergy Action Plan, attached hereto as Exhibit A.

8. We understand that the School reserves the right to cancel Student's enrollment if it is determined that the allergy condition and related consequences are a significant detriment to the Student's ability to benefit from the academic program or to the teachers' ability to maintain order and teach the other students.

9. We hereby indemnify, release, hold harmless and forever discharge the School, its employees and agents from any and all responsibility and/or liability for any injuries, complications or other consequences arising out of or related to Student's food allergy condition.

10. This Release, along with the documents which are incorporated by reference, supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein related to Student's food allergy condition.

11. This Release shall also constitute an estoppel against any and all legal or equitable claims concerning all subject matters covered herein related to Student's food allergy condition; and we, the undersigned parents/guardians, shall further hold harmless and indemnify the School in the event any claim is asserted by any third party against the parties covered by this agreement. The indemnification includes any and all costs and attorneys' fees.

12. **The reference in this Release to the term "the School" includes Archbishop Neale School and Church, the Archdiocese of Washington, a corporation sole, and their affiliates, successors, officers, employees, agents and representatives.**

AGREED AND SIGNED

PARENTS/GUARDIANS
Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date** _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date** _____

PRINCIPAL
Name of Principal: _____

Signature of Principal: _____ **Date** _____

PART IV: To be completed by principal and nurse

Student's Name: _____ Grade: _____ Teacher: _____

CHECKLIST FOR ALLERGY ACTION PLAN

Part I fully completed and signed by parent/guardian and physician/LHCP	☐ Yes	☐ No	
Part II fully completed and signed by parent/guardian	☐ Yes	☐ No	
Part III fully completed and signed by parent/guardian and principal	☐ Yes	☐ No	☐ N/A
Medication is appropriately labeled. The date one week after expiration of LHCP's order is: _____.	☐ Yes	☐ No	☐ N/A
Medication maintained in school designated area (Area:_____)	☐ Yes	☐ No	☐ N/A
***(If LHCP recommends that student self-carry)* Nurse has reviewed proper use of medication with student.**	☐ Yes	☐ No	☐ N/A
Copies of page 1 of Allergy Agreement and Action Plan have been reviewed with and distributed to following school staff:			
Educational Support Agencies working with the student	☐ Yes	☐ No	☐ N/A
After-school program	☐ Yes	☐ No	☐ N/A
Coach/Athletic club supervisor	☐ Yes	☐ No	☐ N/A
Food Service provider	☐ Yes	☐ No	☐ N/A
Staff trained in medication administration	☐ Yes	☐ No	☐ N/A

Name:		Date Trained:		Location:	
Name:		Date Trained:		Location:	
Name:		Date Trained:		Location:	

EXPIRATION **of medication(s):**	

PRINCIPAL and NURSE APPROVAL

Name of Principal: _____

Signature of Principal: _____ **Date:** _____

Name of Nurse: _____

Signature of Nurse: _____ **Date:** _____