ALLERGY AGREEMENT AND ACTION PLAN

Holy Family Catholic School

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

Parent/Guardian Name: _____

Teacher's Name: _____

In the event of a medical emergency for my student, I understand that Holy Family Catholic School will make every attempt to contact me. If the emergency is life-threatening or I cannot be contacted, I authorize the principal or his/her designee, into whose care my student has been entrusted, to consent to any emergency medical treatment that a licensed health care professional or dentist may deem necessary.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care. This authorization shall remain effective for the duration of enrollment at Holy Family Catholic School and updated annually by me unless I revoke it in writing. I also understand that all costs of transportation, hospitalization, and emergency care shall be my responsibility.

To my knowledge the information on this plan is correct and complete. To safeguard my student's health, the school may share this information with school staff to provide a safe and healthy environment for my student.

Students requiring medication at School (prescriptive) including inhalers/epinephrine will require a completed (Medication Authorization Form) on file for each school year, signed by the the parent.

AGREED AND SIGNED:

PARENT/GUARDIANS

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

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

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

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

PRINCIPAL

Name of Principal: **Bridgit Arkoosh**

Signature of Principal: _____ **Date** _____

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ALLERGY AGREEMENT AND ACTION PLAN

Holy Family Catholic School

Student's Name: _____ Weight: _____ Asthmatic: ☐ Yes ☐ No History of Anaphylaxis: ☐ Yes ☐ No

List Allergies: _____ Date of Last Reaction: _____ *mm/dd/yyyy*

Explain what happened during last reaction: _____

Will the student be eating the school hot lunch? ☐ Yes ☐ No **If substitutions are required please have your physician complete the Dietary Accommodation Form**

Will the student be eating at a lunch table specifically designated for life threatening food allergies? ☐ Yes ☐ No

I understand and accept that HFCS employees will NOT check student's lunches from home to determine if they are "peanut and other allergen free". Signature of Parent/Guardian: _____ Date: _____

What types of contact will cause a reaction? ☐ Airborne ☐ Trace Cross Contact ☐ Ingestion ☐ Sting ☐ Other _____

☐ 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:

EARLY/MILD SYMPTOMS ONLY

MOUTH	Itchy mouth or tingly lips
THROAT	Itchy tongue or throat
SKIN	A few hives around mouth/face mild itch
GUT	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE/INHALER**
2. Stay with student, alert parent
3. If symptoms progress see below
4. Begin monitoring

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

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) or blue 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 & begin CPR if not breathing.
3. Begin monitoring & lay student down with legs raised or sit in chair with legs raised. Do not raise student's head or assist to stand.
4. Give antihistamines/inhaler if applicable.
5. A second dose of epinephrine may be given 5 minutes or more after the 1st.

Medications/Doses:

Epinephrine Auto Injector (brand and dose): _____

Antihistamine (brand and dose): _____

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

Name of Parent/Guardian (Print) Signature of Parent/Guardian Telephone Date