Allergy and Anaphylaxis Agreement and Action Plan

Form 6

THE ROMAN CATHOLIC ARCHDIOCESE OF WASHINGTON CATHOLIC SCHOOLS (MD/DC)

Maryland State Department of Education Office of Child Care
Allergy and Anaphylaxis
Medication Administration Authorization Plan

Page 1 is to be completed by the Authorized Health Care Provider.
FOR ALLERGY AND ANAPHYLAXIS MEDICATION ONLY - THIS FORM REPLACES OCC 1216
This form must be completed fully in order for Child Care Providers/staff to administer the required medication and follow the plan. This authorization is NOT TO EXCEED 1 YEAR.

Place Child's Picture Here (optional)

CHILD'S NAME:_______________________________________ Date of Birth:_____/_______/______ **Date of plan**: _______________

Child has **Allergy** to___________________________ Ingestion/Mouth Inhalation Skin Contact Sting Other ____________

Child has had anaphylaxis: Yes No

Child has asthma: Yes No (If yes, higher chance severe reaction)

Child may self-carry medication: Yes No

Child may self-administer medication: Yes No

Allergy and Anaphylaxis Symptoms	Treatment Order	
If child has ingested a food allergen, been stung by a bee or exposed to an allergy trigger	Antihistamine :Oral /By Mouth Call Parent Call 911	Epinephrine(EpiPen) IM Injection in Thigh Call 911 Call Parent
Is Not exhibiting or complaining of any symptoms, OR		
Exhibits or complains of any symptoms below:		
Mouth: itching, tingling, swelling of lips, tongue ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Other:		
If reaction is progressing (several of the above areas affected)		

Potentially life threatening. The severity of symptoms can quickly change

Medication	Medication: Brand and Strength	Dose	Route	Frequency
Epinephrine(EpiPen)				
Antihistamine				
Other:				

EMERGENCY Response:

1) **Inject epinephrine right away! Note time when epinephrine was administered.**
2) Call 911: Ask for ambulance with epinephrine. Advise rescue squad when epinephrine was given. Stay with child.
3) Call parents. Advise parent of the time that epinephrine was given and 911 was called.
4) Keep child lying on his/her back. If the child vomits or has trouble breathing, place child on his/her side.
5) Give other medicine, if prescribed.

PRESCRIBER'S NAME/TITLE		Place stamp here
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) DATE (mm/dd/yyyy)

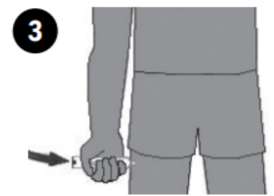
This is image comes from the Food Allergy and Education (FARE), Food Allergy and Anaphylaxis Emergency Care Plan.

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

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

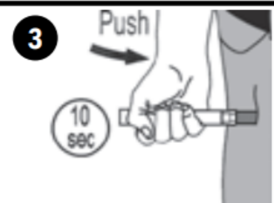
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. 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'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



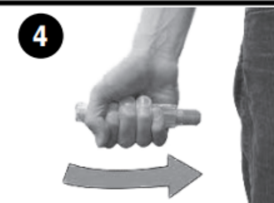
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

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.):

Maryland State Department of Education
Office of Child Care
Allergy and Anaphylaxis
Medication Administration Authorization Plan

Child's Name:____Date of Birth:________________________

PARENT/GUARDIAN AUTHORIZATION		
I request the authorized child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication.		
PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

Emergency Contact(s)	Name/Relationship	Phone Number to be used in case of Emergency
Parent/Guardian 1		
Parent/Guardian 2		
Emergency 1		
Emergency 2		

Section IV. CHILD CARE STAFF USE ONLY				
Child Care Responsibilities:	1. Medication named above was received	Yes	No	
	2. Medication labeled as required by COMAR	Yes	No	
	3. OCC 1214 Emergency Card updated	Yes	No	
	4. OCC 1215 Health Inventory updated	Yes	No	
	5. Modified Diet/Exercise Plan	Yes	No	N/A
	6. Individualized Plan: IEP/IFSP	Yes	No	N/A
	7. Staff approved to administer medication is available onsite, field trips	Yes	No	
Reviewed by (printed name and signature):				DATE (mm/dd/yyyy)

DOCUMENT MEDICATION ADMINISTRATION HERE

DATE	TIME	MEDICATION	DOSAGE	ROUTE	REACTIONS OBSERVED (IF ANY)	SIGNATURE

OCC 1216B REVISED MAY 2022 - all previous editions are obsolete

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 Roman Catholic 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 ________________ to obtain emergency medical treatment for the health of my child, ________________
   School Name *Student Name*
   I will not hold ______________________ responsible for the emergency care and/or emergency transportation for
   School Name
   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 ______________________________ personnel to administer medication,**
   School Name
   including epinephrine, as directed by this authorization. I agree to release, indemnify, and hold harmless the Roman Catholic 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)**: ______________________

Agreement, Release and Wavier of Liability - To be completed by the parent or guardian.

This AGREEMENT, RELEASE AND WAIVER OF LIABILITY (hereinafter referred to as "Release") is made by and between ______________________ (*School Name*), a Roman Catholic elementary school of the Roman Catholic Archdiocese of Washington, and ______________________ (*Parent/Guardian's Name*), parents of ______________________ (*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 ________ (*Enter Year*) 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 all costs and attorneys' fees.

12. **The reference in this Release to the term "the school" includes ______________________ (*School Name*) and Church, the Roman Catholic 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: ________________

School Based Checklist: To be completed by principal and nurse

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

CHECKLIST FOR ALLERGY ACTION PLAN

Pages 1 completed and signed by Licensed Health- Care Provider (LHCP)	Yes	No	
Pages 3 and 4 completed and signed by parent/guardian	Yes	No	
Page 5 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 the Allergy Agreement and Action Plan have been reviewed with and distributed to the following school personnel:			
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: ____________