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*

Parent/Guardian Name: _____

Home Address: _____

_____

Home Phone: **( ) -** _____ Alt. Phone: **( ) - Ext.** _____

Teacher's Name: _____ Grade: _____

Agreement, Release and Waiver of Liability

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

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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 **ST. JUDE REGIONAL CATHOLIC SCHOOL** and Church, the Archdiocese of Washington, a corporation sole, and their affiliates, successors, officers, employees, agents and representatives.

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: _____
Print Principal Full Name

Signature of Principal: _____ **Date** _____

PASTOR

Name of Pastor: _____
Print Pastor Full Name

Signature of Pastor: _____ **Date** _____

Exhibit A on the following pages must be complete and signed before this agreement is signed.

EXHIBIT A
ALLERGY ACTION PLAN

PART I: *This section is to only be completed by the **Parents/Guardians** of the student.*

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

ALLERGY: _____

Teacher's Name: _____ Grade: _____

Is the Student Asthmatic: ☐ NO ☐ YES

CONTACT INFORMATION

In the event of an allergic reaction, the following individuals will be contacted.

Mother/Guardian Name: _____

Home Phone: **( ) -** _____ Alt. Phone: **( ) - Ext.** _____

Father/Guardian Name: _____

Home Phone: **( ) -** _____ Alt. Phone: **( ) - Ext.** _____

Physician/Doctor Name: _____

Office Phone: **( ) -** _____ Alt. Phone: **( ) - Ext.** _____

Please list the names and contact info of two adults who you authorize to make medical decisions if we are unable to reach you.

Contact #1: _____
Last First M.I. (Jr,. III)

Relation to Student: _____ Email Address: _____

Home Phone: **( ) -** _____ Other Phone: **( ) - Ext.** _____

Contact #2: _____
Last First M.I. (Jr,. III)

Relation to Student: _____ Email Address: _____

Home Phone: **( ) -** _____ Other Phone: **( ) - Ext.** _____

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PART II: *This section must be completed by the student's* ***Licensed Health Care Provider.***

TREATMENT PLAN FOR ABOVE ALLERGY

For medications to be administered during school activities, authorization forms accompanying Epipen/Twinject/ or other Medication, must be submitted.

Symptoms	Give ☑ Checked Medication	
• If a food allergen has been ingested, but no symptoms:	☐ Epinephrine	☐ Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth:	☐ Epinephrine	☐ Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities:	☐ Epinephrine	☐ Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea:	☐ Epinephrine	☐ Antihistamine
• Throat***** Tightening of throat, hoarseness, hacking cough:	☐ Epinephrine	☐ Antihistamine
• Lung***** Shortness of breath, repetitive coughing, wheezing:	☐ Epinephrine	☐ Antihistamine
• Heart***** Unsteady/weak pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine	☐ Antihistamine
• Other _____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected) then give:	☐ Epinephrine	☐ Antihistamine

*****_Potentially life-threatening. The severity of symptoms can quickly change._

DOSAGE

Epinephrine: Inject intramuscularly (✓one of the following) ☐ EpiPen® ☐ EpiPen® Jr. ☐ Twinject

Antihistamine: _____
Indicate the Type of Medication, Dosage Amount, and Route

Other: _____
Indicate the Type of Medication, Dosage Amount, and Route

IN CASE OF A MEDICAL EMERGENCY

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Call Dr. _____ at _____
Please Print Physician's Name *Phone or Pager Number with Extension, if applicable*

Licensed Health Care Professional Approval

Name of Licensed Professional: _____
Print Licensed Health Care Provider's Name

Signature of Licensed Professional: _____ **Date** _____

PART III: *This section must be completed by the school* ***Principal or Registered Nurse.***

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

ALLERGY: _____

CHECKLIST FOR ALLERGY ACTION PLAN

• Part I of Allergy Action Plan fully completed by Parent/Guardian	☐ Yes	☐ No	
• Part II of Allergy Action Plan fully completed by Licensed Health Care Provider	☐ Yes	☐ No	
• Medication Authorization fully completed	☐ Yes	☐ No	☐ N/A
• Epinephrine Authorization fully completed	☐ Yes	☐ No	☐ N/A
• Medication maintained in school designated area (Area:_____)	☐ Yes	☐ No	☐ N/A
• Medication self carried by the student	☐ Yes	☐ No	☐ N/A
• Copies of Allergy Action Plan Provided to the following:			
Educational Support Agencies working with the student	☐ Yes	☐ No	☐ N/A
After-school program	☐ Yes	☐ No	☐ N/A
Athletic club/coach	☐ 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): _____

Name of Principal or Registered Nurse: _____
Print Full Name

Signature of Principal or Registered Nurse: _____ **Date:** _____

PART IV: *This section must be completed by the* ***Parent.***

PERMISSION FOR EMERGENCY TREATMENT & PARENT/GUARDIAN CONSENT

In the event the parent/guardian named on this form cannot be contacted, I the undersigned parent, do hereby authorize ST. JUDE REGIONAL CATHOLIC SCHOOL to obtain emergency medical treatment for the health of my child,

_____. I will not hold ST. JUDE CATHOLIC SCHOOL responsible for
Print Student's Full Name
the emergency care and/or emergency transportation for the said student.

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.

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

Signature of Parent/Guardian: _____ Date _____