



ANAPHYLAXIS EMERGENCY PLAN 2017-2018

If your child has a potential life threatening allergy please fill out the following form, along with the **Administration of Medication** form, which are to be reviewed and signed by your child’s physician. Please ensure to provide a second (backup) epinephrine injector to the office.

Student Details

Affix student photo here

Student Name	<input type="text"/>	Grade	<input type="text"/>
CareCard Number (PHN)	<input type="text"/>	Date of Birth	<input type="text"/>
Mother/Guardian’s Name	<input type="text"/>	Mother/Guardian’s Phone	<input type="text"/>
Father/Guardian’s Name	<input type="text"/>	Father/Guardian’s Phone	<input type="text"/>
Alternate Emergency Contact	<input type="text"/>	Alternate Contact’s Phone	<input type="text"/>

Potential life-threatening allergies (anaphylaxis)

Please check off the allergens which cause an anaphylactic reaction:

- | | | | |
|----------------------------------|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Tree nuts | <input type="checkbox"/> Eggs | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Milk | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Soy |

Other - please describe:

Symptoms

Please check-off the symptoms to look for in case of an anaphylactic reaction:

- | | | |
|--|---|---|
| <input type="checkbox"/> Swelling (eyes, lips, face, tongue) | <input type="checkbox"/> Dizziness or Confusion | <input type="checkbox"/> Stomach Cramps |
| <input type="checkbox"/> Difficulty breathing or swallowing | <input type="checkbox"/> Coughing, Wheezing | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Flushed face or body | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Voice Changes |
| <input type="checkbox"/> Hives, rash | <input type="checkbox"/> Chest Pain/ Tightness | <input type="checkbox"/> Trouble Swallowing |

Other - Please Specify:

Risk Level

- Previous anaphylactic reaction: Person is at greater risk.
- Asthmatic: Person is at greater risk. If the person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

Epinephrine Auto-Injector

Your child should carry an epinephrine auto-injector at all times. It should not be stored in a locker. A second (backup) epinephrine auto-injector is to be kept at the school office. Please ensure that both auto-injectors are kept current throughout the year.

Epinephrine Auto-Injector Type:

- EpiPen® Jr 0.15 mg
- EpiPen® 0.30 mg

Injector Expiry Date:

Injector 1 (in your child's backpack)

Injector 2 (kept in school's office)

Emergency Procedures

Give epinephrine auto-injector at the first sign of a known or suspected anaphylactic reaction. Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

Call 9-1-1 or local emergency medical services. Tell them someone is having a life-threatening allergic reaction.

Give a second dose of epinephrine in 5 to 15 minutes IF the reaction continues or worsens.

Go to the nearest hospital immediately (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment.

Call emergency contact person (e.g. parent, guardian).

Authorization

The undersigned patient, parent or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been reviewed and recommended by the patient's physician.

Signature of Parent/Guardian

Parent/Guardian Name

Date (YY/MM/DD)

Signature of Physician

Physician Name

Date (YY/MM/DD)

Physician's Address

Physician's Phone



ADMINISTRATION OF MEDICATION 2017-2018

Instructions

All health forms must be updated at the beginning of each school year. A new form is to be completed if the medication or dosage changes.

If you would like school personnel to administer medication to your son/daughter, please complete this form.

Sections A is to be completed by the parent/guardian. Please print the form for your child's prescribing physician to fill out Section B.

Prescription medication cannot be given until this form is completed and returned to the school. Medication must be provided in a container with a label from the pharmacy. Many pharmacies can provide an additional labelled container upon request. Herbal and over-the-counter medication **MUST** be in the original, clearly labelled container.

Parents are responsible for checking expiry dates of medications and providing refills as necessary.

The school staff will keep a medication log for your child.

A. To be completed by parent or guardian

Student Name	Grade	Date of Birth (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Parent or Guardian	Home Phone	Work Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>
Physician	Physician's Phone	
<input type="text"/>	<input type="text"/>	

Authorization

I request the school staff to give medications to my child as prescribed by my child's physician, **as listed on page 2 of this form.**

I will notify the school promptly of any changes in medications or medication dosages. I understand that I will need to have a new **Administration of Medication** form filled out by myself and my child's physician.

Parent/Guardian Signature	Date (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>

B. To be completed by prescribing physician

Student Name	Grade	Date of Birth (DD/MM/YYYY)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Name of Medication	Condition(s) Treated by Medication	Dosage	Directions for Use
<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>
<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>
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<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>	<input style="width: 100%; height: 50px;" type="text"/>

Additional comments, possible reactions, and/or consequences of missing medication

Date (DD/MM/YYYY)	Physician's Signature
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>