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ANAPHYLAXIS EMERGENCY PLAN 2018-2019

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

Grade

CareCard Number (PHN)

Date of Birth

Mother/Guardian's Name

Mother/Guardian's Phone

Father/Guardian's Name

Father/Guardian's Phone

Alternate Emergency Contact

Alternate Contact's Phone

Potential life-threatening allergies (anaphylaxis)

Please check off the allergens which cause an anaphylactic reaction:

- ☐ Peanuts
- ☐ Tree nuts
- ☐ Eggs
- ☐ Seafood
- ☐ Latex
- ☐ Milk
- ☐ Insect Stings
- ☐ Soy

Other - please describe:

Symptoms

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

- ☐ Swelling (eyes, lips, face, tongue)
- ☐ Difficulty breathing or swallowing
- ☐ Flushed face or body
- ☐ Hives, rash
- ☐ Dizziness or Confusion
- ☐ Coughing, Wheezing
- ☐ Shortness of Breath
- ☐ Chest Pain/ Tightness
- ☐ Stomach Cramps
- ☐ Nausea
- ☐ Voice Changes
- ☐ Touble Swallowing
- ☐ Other - Please Specify:

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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 _____

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ADMINISTRATION OF MEDICATION
2018-2019

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)

Parent or Guardian	Home Phone	Work Phone

Physician	Physician's Phone

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)

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ADMINISTRATION OF MEDICATION
2018-2019

B. To be completed by prescribing physician

Student Name	Grade	Date of Birth (DD/MM/YYYY)

Name of Medication	Condition(s) Treated by Medication	Dosage	Directions for Use

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

Signature of Physician	Physician Name	Date (YY/MM/DD)

Physician's Address	Physician's Phone