ANAPHYLAXIS EMERGENCY PLAN 2020-2021

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 also provide a second (backup) EPIPEN to the office.

Student Details

Affix student photo here

Student Name

Grade

CareCard Number (PHN)

Date of Birth (DD/MM/YYYY)

Mother/Guardian's Name

Mother/Guardian's Phone

Father/Guardian's Name

Father/Guardian's Phone

Alternate Emergency Contact

Alternate Contact's Phone

Anaphylactic Allergies:

Please check off the allergens which cause an anaphylactic reaction:

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

Other - please describe:

What are the known levels of reactivity? E.g. ingestion, contact, airborne?

Risk Factors

- ☐ 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 EPIPEN before asthma medication. Please also fill out an **Asthma Plan** form.

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EPIPEN (Epinephrine Auto-Injector)

Your child should carry an EPIPEN with them at all times, including during PE, school activities and field trips, and on school buses. The EPIPEN should not be stored in a locker. A second (backup) EPIPEN is to be kept at the 5th Floor Office. Please ensure that both EPIPENs are kept current throughout the year.

EPIPEN Type: ☐ EpiPen® Jr 0.15 mg ☐ EpiPen® 0.30 mg

	Location (e.g. backpack)	EPIPEN Expiry (MM/YYYY)
EPIPEN 1 (with student)		
EPIPEN 2 (backup)	5th Floor Office	

Known Anaphylactic Symptoms

Please check-off your child's usual symptoms during an anaphylactic reaction (if known):

- ☐ 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:

Anaphylaxis First Aid Procedures

If the student is having an anaphylactic reaction, follow these procedures immediately:

Place student in a comfortable position. If unconscious, place them in the recovery position. If breathing is difficult, allow them to sit leaning forward.

Give the EPIPEN 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 . Tell them the student is having a life-threatening allergic reaction, and an EPIPEN has been administered. **The student will need to go to the hospital, by ambulance,** even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment.

Give a second dose of epinephrine in 5 to 15 minutes IF the reaction continues or worsens, or as advised by 9-1-1 operator.

Call parents/guardians. If parents/guardians can't be reached, call the student's emergency contact.

Additional Anaphylaxis Plan Instructions:

Parent Authorization

I agree with the plan of care outlined in this document. I am aware that the school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith.

I understand that it is my responsiblity to provide an updated plan for each new school year, as well as if my child's condition, anaphylaxis plan, and/or medication changes. If I wish to cancel this plan, I will do so in writing.

I authorize the school to share this plan and it's information with any relevant staff, for the purposes related to education, health and safety of my child. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Physician Authorization

I have reviewed and am in agreement with the information contained in this Anaphylaxis Plan.

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

Physician's Address	Physician's Phone

ADMINISTRATION OF MEDICATION
2020-2021

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.

Section 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

Parent / Guardian 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. If I wish to cancel the administration of medication, I will do so in writing.

I am aware that the school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith. I authorize the school to share this plan and it's information with any relevant staff, for the purposes of administering this child's medication. Information shared will be subject to the school's Privacy Policy.

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

Signature of Parent/Guardian	Parent/Guardian Name	Date (DD/MM/YYYY)

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ADMINISTRATION OF MEDICATION
2020-2021

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

Physician Authorization

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

Physician's Address	Physician's Phone