peel District School Board

PREVALENT MEDICAL CONDITION — ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name _______________ Date Of Birth ______________ Student Picture (Optional)

SIS # ________________ Age _____________________

Grade _____________________ Teacher(s) ________________

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

❒ Food(s): ___________________________ ❒ Insect Stings: __________________________

❒ Other: ____

Epinephrine Auto-Injector(s) Expiry Date (s): ________________ **Dosage:** ❒ EpiPen® Jr. 0.15 mg ❒ EpiPen® 0.30 mg

Students must keep Epi-Pens with them at all times

❒ Previous anaphylactic reaction: **Student is at greater risk.**
❒ Has asthma. **Student is at greater risk**. If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.
❒ Any other medical condition or allergy?_______________________________________

DAILY/ROUTINE ANAPHYLAXIS MANAGEMENT

SYMPTOMS: A STUDENT HAVING AN ANAPHYLACTIC REACTION MIGHT HAVE ANY OF THESE SIGNS AND SYMPTOMS:

Skin system: hives, swelling (face, lips, tongue), itching, warmth, redness.

Respiratory system (breathing): coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.

Gastrointestinal system (stomach): nausea, vomiting, diarrhea, pain or cramps.

Cardiovascular system (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or light headedness, shock.
Other: anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste.
EARLY RECOGNITION OF SYMPTOMS AND IMMEDIATE TREATMENT COULD SAVE A PERSON'S LIFE.

Avoidance of an allergen is the main way to prevent an allergic reaction.

Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.

Food(s) to be avoided: ____

Safety measures: ____

Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where stinging insects nest or congregate. Destroy or remove nests, cover or move trash cans, keep food indoors.)

Designated eating area inside school building: ____

Safety measures:

EMERGENCY PROCEDURES
(DEALING WITH AN ANAPHYLACTIC REACTION)

ACT QUICKLY. THE FIRST SIGNS OF A REACTION CAN BE MILD, BUT SYMPTOMS CAN GET WORSE QUICKLY.

STEPS

1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of a known or suspected anaphylactic reaction.
   i) Pull off the safety cap from the Epi-Pen
   ii) Grasp the shaft of the pen- not the end of the device
   iii) Press the tipped end of the auto-injector against the student's upper thigh applying moderate pressure and listen for a click which indicates the device has been activated.
   iv) Keep pressed against thigh and hold for a count of 10 (e.g., one-one thousand, two-one thousand etc.) Remove the pen with caution as the needle is now exposed.
   v) Keep the child calm
2. Call 9-1-1. Tell them someone is having a life-threatening allergic reaction. Stay with student and monitor symptoms until the ambulance arrives.
3. Give a second dose of epinephrine as early as five (5) minutes after the first dose if there is no improvement in symptoms.
4. Follow direction of emergency personnel, including transport to hospital (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 - 6 hours).
5. Call emergency contact person; e.g. Parent(s)/Guardian(s).

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: ________________________________ Profession/Role: ________________________

Special Instructions/Notes/Prescription Labels:____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✷This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _______________________ 2. ______________________ 3. ___________________________
4._______________________ 5. _______________________ 6. __________________________

Other individuals to be contacted regarding Plan of Care:

Before-School Program ❒Yes ❒ No ____________________________
After-School Program ❒ Yes ❒ No ____________________________

School Bus Driver/Route # (If Applicable) ____

Other: ____

This plan remains in effect for the 20___- 20___ school year without change and will be reviewed on or before: __________________________________. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

I/We hereby request that the Peel District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The Peel District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardians and students acknowledge that the employees of the Peel District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parents to ensure that clear instructions and current physician's orders are provided to the principal.

Authorization for the collection of this information is in the Education Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act, as amended and as applicable. This form will be kept for a minimum period of one calendar year. The contact person concerning this collection is the school principal.

Parent(s)/Guardian(s)Signature: _____________________________ Date: _________________________
Student Signature: ____ Date_________________________
Principal Signature: ____ Date: _________________________