

ANAPHYLAXIS HEALTH CARE PLAN

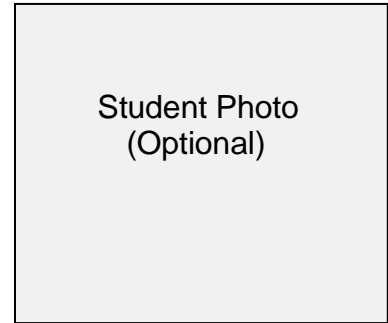
STUDENT INFORMATION

School: _____

Student Name: _____ Date of Birth: _____

Age: _____ School: _____

Grade: _____ Teacher: _____



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

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® EpiPen®
Jr. 0.15 mg 0.3 mg

Location of Auto-Injector(s): _____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

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 color/blue color, 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.



Date: _____

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: _____

Other information: _____

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program Yes No _____

After-School Program Yes No _____

School Bus Driver Route #: _____

Other: _____



Date: _____

This plan remains in effect for the 20 __ - 20 __ school year without change and will be reviewed on or before: _____ unless otherwise notified by parents of need to revisit the Plan. 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 York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region 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)/guardian(s) acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

Parent(s)/Guardian(s): _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

- Distribution: Original: Secure location accessible by school staff
- Original: Scanned and uploaded to SSNET
- Original: Scanned and sent to Student Transportation Services
- Copy: Parent/Guardian
- Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:
Medical Incident Record Form (accessed via SSNET)