

# ANAPHYLACTIC REACTIONS PROTOCOL

TO BE COMPLETED BY PARENT/GUARDIAN AND SCHOOL

\*ANNUAL UPDATE REQUIRED

STUDENT'S NAME (please print): \_\_\_\_\_

HOMEROOM TEACHER'S NAME: \_\_\_\_\_

My child has been diagnosed as having a potentially life-threatening allergy (anaphylaxis) by a medical professional and is allergic to:

\_\_\_\_\_

<p>Student Address</p> <p>_____</p> <p>_____</p> <p>Emergency Contact 1 Phone #</p> <p>_____</p> <hr/> <p>Emergency Contact 2 Phone #</p> <p>_____</p> <hr/> <p>Emergency Contact 3 Phone #</p> <p>_____</p> <p>_____</p> <p>Physician's Name: _____</p> <p>Phone # _____</p>	<p><b>PLACE PHOTO HERE</b> (Parent/guardian to provide photo upon registration and September of each of the following years)</p>	<p><b>Prescribed epinephrine auto-injector(s) are kept:</b></p> <p>With student <input type="checkbox"/></p> <p>In office <input type="checkbox"/></p> <p>Other: _____</p> <hr/> <p><b>Type of epinephrine auto-injector prescribed:</b></p> <p>Epi-Pen <input type="checkbox"/></p> <p>Other: _____ <input type="checkbox"/></p> <p>Dose <input type="checkbox"/> 0.15 mg <input type="checkbox"/> 0.3 mg</p> <p><b>Expiry date:</b></p> <p>_____</p>
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<p><b>POSSIBLE SYMPTOMS:</b></p> <p><input type="checkbox"/> Skin: hives, swelling (face, lips, tongue), itching, warmth, redness</p> <p><input type="checkbox"/> Respiratory (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</p> <p><input type="checkbox"/> Cardiovascular (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or lightheadedness, shock</p> <p><input type="checkbox"/> Gastrointestinal (stomach): nausea, pain or cramps, vomiting diarrhea</p> <p><input type="checkbox"/> Other: anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste.</p> <p>Please list:</p>
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<b>ACTION – EMERGENCY PLAN:</b>	
<input type="checkbox"/>	Use epinephrine auto-injector immediately.
<input type="checkbox"/>	DESIGNATE SOMEONE TO CALL 911 Emergency Medical Services and advise the dispatcher that a student is having an anaphylactic reaction (a severe life-threatening allergic reaction).
<input type="checkbox"/>	Call emergency contacts listed above.
<input type="checkbox"/>	Give a second dose of epinephrine as early as 5 minutes after the first dose if there is no improvement in symptoms
<input type="checkbox"/>	The student must be taken to a hospital immediately (ideally by ambulance), even if symptoms are mild or have stopped. Student is to stay in the hospital for a period of observation (generally 4-6 hours).
<input type="checkbox"/>	Send epinephrine auto-injector with the ambulance.

I realize that it is my responsibility to:

- ☐ provide at least one in-date epinephrine auto-injector to be used at the school annually;
- ☐ ensure that my child carries his/her epinephrine auto-injector at all times;
- ☐ provide a second epinephrine auto-injector if possible, and understand that the second epinephrine auto-injector will be administered as early as five (5) minutes after the first does if there is no improvement in symptoms;
- ☐ alert the school to my child's life-threatening allergies by completing the anaphylactic reactions protocol upon registration of my child and each September if my child is a returning student;
- ☐ replace the epinephrine auto-injector before the listed expiry date and after use;
- ☐ provide a current picture of my child to the office each September; and
- ☐ call the school to schedule a meeting with the teacher/principal to discuss my child's anaphylactic reactions protocol if I so choose.

I understand that the severity of my child's reaction and/or anxiety may hinder any attempt to self-administer medication and as a result, my child may require the assistance of staff members.

I give permission to the principal to:

- post my child's picture and a copy of this form anywhere in the school accessible to staff so that all staff are alerted to this situation;
- share this information with before and after school program providers;
- share this information with Student Transportation Services; and
- share this information with cafeteria services in secondary schools.

Parent/guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Personal information on this form is collected under the authority of the Education Act, R.S.O. 1990, c.E.2 and the Municipal Freedom of Information and Protection of Privacy Act, R.S.O., 1990, c.M.56.*