HWDSB

Appendix B

ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

OEN # _____ Age _____

Grade _____ Teacher(s) _____

Student Photo (optional)

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 Location Of Auto-Injector(s): _____

☐ 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? _____

Post copy of page one in staff only area

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 lightheadedness, 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: _____

_____

Other information: _____

_____

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.

2. Call 9-1-1. 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. 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

Healthcare provider may include: Physician or Nurse Practitioner

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please complete the Authorization of Administration of Oral Prescription Medication (Appendix F).
✸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.)

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

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Information on this form is collected under the legal authority of the Education Act and in accordance with Sections 28 and 29 of the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 (MFIPPA). The purpose of the form is to support children with prevalent medical conditions and foster healthy and safe environments in which students can learn. We take your privacy seriously and have policies in place to make sure your information is protected (see our Privacy and Information Management Policy 1.6). Questions or concerns should be directed to your school principal.

File in student Prevalent Medical Conditions folder with Plan of Care. Also file a copy in the OSR. Retain until superseded or no longer in effect.