



# INDIVIDUAL ANAPHYLACTIC PLAN

**SECTION A (to be completed by parent/guardian in consultation with the physician)**

*Please print*

**STUDENT'S NAME:** \_\_\_\_\_ **Birthdate:** Year \_\_\_\_ Month \_\_\_\_ Day \_\_\_\_

**STUDENT'S HEALTH CARD NUMBER:** \_\_\_\_\_

Parent/Guardian's Name: a) \_\_\_\_\_ b) \_\_\_\_\_

**Telephone Contact Information**

a) Parent/Guardian Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

b) Parent/Guardian: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**DOCTOR'S NAME** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

<b>Description of Allergy</b>	
<b>Food / Events / Conditions which are to be avoided</b>	
<b>Eating Restrictions</b>	
<b>Possible Symptoms</b>	

**MEDICAL CERTIFICATION:**

**THIS IS TO CERTIFY THAT** \_\_\_\_\_ **HAS AN ANPHYLACTIC**

**REACTION TO** \_\_\_\_\_ **AND MUST BE GIVEN EPINEPHRINE**

**AUTO-INJECTOR (EpiPen®) IN THE EVENT OF AN ALLERGIC REACTION.**

**DOCTOR'S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*(This medical certification is valid until revoked by the parent and / or physician)*

**PARENT / GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_



# CONSENT FORM

**(to be signed by parent/guardian unless the student is 18 years of age or older)**

**Administration of Medication**

In the event of my child \_\_\_\_\_ experiencing an anaphylactic medical emergency, I consent to the administration of an epinephrine auto-injector by an employee of the Hamilton-Wentworth District School Board as outlined in the Emergency Procedures.

*Please Print*

Student's Name \_\_\_\_\_ Class \_\_\_\_\_

Name of Parent / Guardian \_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student \_\_\_\_\_ Date: \_\_\_\_\_  
(if 18 years of age or older)

**Maintenance of Epinephrine Auto-Injector**

I understand that it is the responsibility of my child \_\_\_\_\_ to carry an epinephrine auto-injector on his/her person.

*Please Print*

Student's Name \_\_\_\_\_ Class \_\_\_\_\_

Name of Parent / Guardian \_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student \_\_\_\_\_ Date: \_\_\_\_\_  
(if 18 years of age or older)

**Collection, Disclosure and Use of Personal Information**

Authorization for the collection and maintenance of the personal information recorded on the Individual Anaphylaxis Plan form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information are supervisory officers and/or school staff. Any questions regarding the collection of personal information should be directed to the principal of the school.

I hereby consent to the use of personal information contained herein by the persons above named and by such other officers or employees of the Board including the school Public Health Nurse, who may need the personal information in the performance of their duties.

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not employees of The Hamilton-Wentworth District School Board through the posting of photographs and medical information of my child (Emergency Procedures) in the following key locations:

*(please check applicable boxes)*

- classroom                       staffroom                       lunchroom                       gym
  - office                       school bus                       other  \_\_\_\_\_ and
- through the provision of personal information contained herein to the following persons who are not employees of the Board: *(please check applicable boxes)*
- Food services providers
  - Board-approved transportation carriers
  - School volunteers in regular direct contact with my child.

I UNDERSTAND THAT, PURSUANT TO SABRINA'S LAW, 2005, ONLY EMPLOYEES OF THE HAMILTON-WENTWORTH DISTRICT SCHOOL BOARD ARE AUTHORIZED TO ADMINISTER EPINEPHRINE INJECTIONS.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of principal \_\_\_\_\_ Date \_\_\_\_\_

# EMERGENCY PROCEDURES

\_\_\_\_\_ (name)

This student has a DANGEROUS life-threatening allergy to:

Photo	<input type="checkbox"/> Peanut <input type="checkbox"/> Tree nuts <input type="checkbox"/> Egg <input type="checkbox"/> Milk <input type="checkbox"/> Insect Stings <input type="checkbox"/> Medication:- <input type="checkbox"/> Other: _____ <p><b>Food:</b> The key to preventing an anaphylactic emergency is avoidance of the allergen. Individuals with food allergies cannot share food, eat unmarked/bulk foods, or products that have the "may contain" warning.</p>
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**KNOW THE SIGNS & SYMPTOMS...a person with anaphylaxis might have any of the following signs or symptoms:**

**Face:** Itchy eyes, itchy nose, flushed face, swollen lips, swollen tongue

**Airway:** Trouble breathing or swallowing, hoarseness, choking, coughing, wheezing

**Stomach:** Pain, vomiting, diarrhea

**Skin:** Rash, itchiness, swelling, hives - anywhere on the body

**General:** Weakness, sense of doom, loss of consciousness

*Anaphylaxis can lead rapidly to unconsciousness and death.*

**KNOW WHAT TO DO...the first signs of a reaction can be mild, but symptoms can get worse very quickly.**

## EMERGENCY PROCEDURES

1. **LOCATION** of epinephrine auto-injectors 1. \_\_\_\_\_ 2. \_\_\_\_\_
2. **ADMINISTER** the epinephrine auto-injector at the first sign of a reaction. It is dangerous to wait. Give a second dose in 10 - 15 minutes if reaction continues or worsens.
3. **CALL 911:** \_\_\_\_\_ (Name of School) \_\_\_\_\_ We have a student who is allergic to \_\_\_\_\_ and is in respiratory distress. We have administered an epinephrine auto-injector. We need an ambulance sent to (address of school) \_\_\_\_\_. The nearest major intersection is \_\_\_\_\_.
4. **OFFICE CALLS THE PARENTS/GUARDIANS.**
5. **STAY WITH THE STUDENT.** Keep the child quiet. A second epinephrine auto-injector may be needed in 10-15 minutes if reaction continues or worsens.

**\*\*CONTACT INFORMATION BELOW TO BE FILLED IN FOR USE IN OFFICE / STAFFROOM COPY ONLY\*\***

**CONTACT NAMES / PHONE NUMBERS / APPROVAL**

	Home:	Work:	Cell:
	Home:	Work:	Cell: