School District 69 (Qualicum)

Appendix IV – Student Health and Common Medical Conditions

PLAN OF CARE — ANAPHYLAXIS

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

P.E.N. # _____ 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? _____

Does the student carry his/her own EpiPen? ❒ Yes ❒ No

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: _____

_____

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 (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: _____

Signature: _____ Date: _____

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.)

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

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

STUDENT'S NAME:_____ SCHOOL:_____

Parent Information/Authorization (*Please initial here as appropriate and sign on Page 2 of this form*)

_____ I agree to supply the school with an up-to-date EpiPen(s).

_____ I agree to provide the student with a medic alert bracelet and fanny pack for the EpiPen.

_____ I agree to ensure that the student understands his/her responsibilities for his/her safety.

_____ I agree to ensure that the student will have an EpiPen on his/her person at all times while at school.

_____ I understand that my failure to do any of the above may result in an inability to implement timely emergency procedures for this potentially life threatening condition.

_____ I authorize the staff of School District 69 (Qualicum) and its agents including volunteers to execute the ANAPHYLAXIS EMERGENCY PLAN herein outlined.

_____ I give consent for the identification of my son/daughter as a person with a life-threatening allergy and I understand that this may include the display of pertinent information in strategic locations within the school in order to ensure that staff are able to respond to emergencies. School District 69 (Qualicum) affirms its commitment to maintain confidentiality and to enhance student self-esteem to the greatest extent possible in these circumstances and to respond to concerns regarding confidentiality which may arise.

_____ If changes occur in the condition of my son/daughter, in his/her medications or recommended treatments I agree to provide to the school in a timely manner any information which is appropriate in order to ensure safety.

Student Information/Authorization (Please initial here as appropriate and sign on Page 2 of this form)

_____ I agree to inform my school principal any time that I experience an anaphylactic reaction during the school day.

Physician Information/Authorization (Please initial here as appropriate and sign on Page 2 of this form)

For the student named above, please identify the allergen(s) or "triggering" condition(s) which could be expected to cause an anaphylactic reaction: Peanuts ___ Nuts ___ Dairy ___ Insects___ Latex ___
Others foods _____
Other_____

Please describe the symptoms which might be expected (initial as appropriate)

_____ Skin - hives, swelling, itching, warmth, redness, rash.
_____ Respiratory (breathing) - wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain, nasal congestion, hay-fever like symptoms (runny, itchy nose and watery eyes, sneezing, trouble swallowing.
_____ Gastro-intestinal (stomach) - nausea, pain/cramps, vomiting, diarrhea.
_____ Cardio-vascular (heart) - pale/blue colour, weak pulse, passing out, dizzy/light-headed, shock.
_____ Other: anxiety, feeling of "impending doom", headache, uterine cramps (in females)

Additional symptoms/comments_____

_____