

**PREVALENT MEDICAL CONDITION-ANAPHYLAXIS
PLAN OF CARE**

STUDENT INFORMATION

Student Photo

Student Name _____ Date of Birth _____

Ontario Ed # _____ Age _____

Grade _____ Teacher _____

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 Sting(s): _____
- Other: _____

Epinephrine Auto-Injector(s) Expiry Date(s): _____

- Dosage: EpiPen Jr. 0.15 mg EpiPen 0.30 mg Location of Auto-Injectors(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? _____

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 Allergens(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.

- 1. Give epinephrine auto-injector** (e.g. EpiPen or Allerject) at the first sign of a 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 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 proper 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, guardian).**



FORM Nbr: SA 10116

DATE: June/19

HEALTHCARE PROVIDER INFORMATION

Healthcare provider may include: Physician or Nurse Practitioner

Healthcare Provider's Name: _____

Profession: _____

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