Dufferin-Peel Catholic District School Board

Plan of Care – Prevalent Medical Condition

ANAPHYLAXIS

STUDENT SPECIFIC

Student Name: _____ Date of Birth: _____ Age: _____

OEN Number: _____ Teacher: _____ Grade: _____

Medical Alert ID: Yes ☐ No ☐ (for high schools, indicate Semester 1 Homeroom Teacher)

Insert Student Photo

Emergency Contact Information:

Name:	Relationship:	Contact Numbers:

Known life-threatening triggers:

Food	CODE (P, A, I, X)	Insect Stings		Medication	CODE (P, A, I, X)	Other:	CODE (P, A, I, X)

Please indicate the nature of the reaction (code each allergen accordingly)

P – Physical contact with the allergen may cause an anaphylactic reaction

A – Airborne contact with the allergen may cause an anaphylactic reaction

I - Ingestion contact with the allergen may cause an anaphylactic reaction

X - all of the above may cause an anaphylactic reaction

Avoidance of allergen is the main way to prevent an allergic reaction. (see GAP 510.10 - for list) Safety Measures to take are: _____

Daily Routine Anaphylaxis Management:
(to be completed by a physician)

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

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

Dosage: EpiPen Jr 0.15 mg ☐ EpiPen 0.30 mg ☐

Administer epinephrine to _____
(body part)

Location of Auto-Injector(s): _____ ☐ No EpiPen will be sent to the school.
(with student, main office, backpack)

Specific Directions: _____
(e.g. refrigeration, reactions etc)

☐ Student has had a previous anaphylaxis reaction. Therefore, student is at greater risk.

☐ Student has asthma. Therefore, student is at greater risk. IF STUDENT IS HAVING A REACTION AND HAS DIFFICULTY BREATHING, ***GIVE EPINEPHRINE BEFORE ASTHMA MEDICATION***.

☐ Student has another medical condition / allergy. _____

The parent(s)/guardian(s) of the child named above have requested the Dufferin-Peel Catholic District School Board to offer a service for the administration of epinephrine medication in an emergency to their child in the school. The Board requires a Doctor's approval before implementing such a program. Please sign below.

Healthcare Provider's Name: _____ ***Profession / Role:*** _____

Signature: _____ ***Date:*** _____
(Health Care Provider)

Administrative / Plan Review

Individuals with whom this Plan of Care is to be shared:

☐ Principal or Principal Designate ☐ Teacher-in-Charge ☐ Administrative Assistant (s)

☐ Classroom Teacher(s) ☐ Planning Time Teacher(s) ☐ Resource Teacher(s) / Support Services

☐ Student Monitors/ Volunteers ☐ Occasional Teachers ☐ Food Service Provides (e.g. Cafeteria)

Other individuals to be contacted regarding Plan of Care:

☐ PLASP / Daycare ☐ Transportation ☐ Other: _____

Parent(s)/ Guardian(s) Request and Consent:

As the parent of _____, I have been an active participant in supporting the management of my child's medical condition(s) while he/she is in school. I understand that the goal of the board's anaphylaxis policy is to provide a safe environment for our child with a life-threathening allergy, ***but it is not possible for the school to reduce the risk to zero.***

☐ Teachers and Principals and other school staff are not health professionals and have no more information about the medical condition of my child than that which has been provided to them. They are not experts in recognizing the symptoms of my child's medical condition or in treating it.

☐ A Medical Doctor has reviewed and signed the consent provided on page 2.

☐ The epinephrine medication has been brought to the school in an enclosed container labelled with my child's name, type/name of medication and size of dosage.

☐ I give consent that GF _____ with the picture of my child can be posted in appropriate locations of the school (e.g. health room, staffroom, classroom)

☐ I have educated my child about his/her medical condition.

☐ I have encouraged my child to self-manage and self-advocate.

☐ I have informed the school of my child's medical condition(s) and will communicate any changes or updates.

This plan remains in effect for the _____ school year without change and will be reviewed annually.

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 – if applicable)

Principal: _____ ***Date:*** _____
(signature)

ACTIONS TO TAKE: (A.C.T.)

A: Administer the epinephrine immediately when the child displays any of the anaphylactic 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

C: Call 911. Notify parents as soon as possible.

T: Transport the child by ambulance to the hospital – even if symptoms subside.

Additional steps to take:

1. ***Complete and submit OSBIE form.***