



## PREVALENT MEDICAL CONDITION — ANAPHYLAXIS Plan of Care

### STUDENT INFORMATION

Student Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Ontario Ed. # \_\_\_\_\_ 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? \_\_\_\_\_

## 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 (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