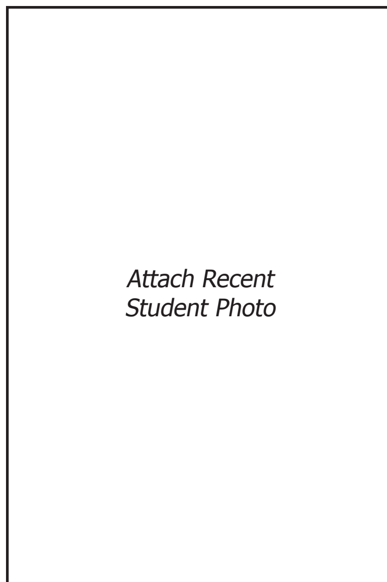
Anaphylactic Student Emergency Procedure Plan

To Be Reviewed Annually



Student Information - please print

Name: ______________________________
First Name *Last Name*

Date of Birth: ______________________ ☐ Male ☐ Female
Month *Day* *Year*

Parent(s) / Guardian(s) with whom the student resides:

____
First Name *Last Name*

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________ Email Address: ______________

Emergency Contact: ______________________________
First Name *Last Name*

Daytime Phone: ______________ Cell/Work Phone: ______________

Teacher's Name: ______________________________

Allergy Information - to be completed by the physician

Physician's Name: ______________________ Clinic: ______________

Daytime Phone: ______________________ Fax Number: ______________

Allergen (please do not include antibiotics or other drugs):

☐ Peanuts ☐ Nuts ☐ Dairy ☐ Other Food: ______________

☐ Insects ☐ Latex ☐ Other: ______________

Symptoms (please highlight those that apply):

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

Emergency Protocol

- Administer single dose, single-use auto-injector and call 911.
- One person stays with the student at all times.
- Notify parent/guardian.
- Administer second auto-injector in 10 to 15 minutes if symptoms do not improve or if symptoms recur.
- Have ambulance transport student to hospital.

Emergency Medication - to be completed by the physician

NOTE: Emergency medication must be a single-dose, auto-injector for school setting. Oral antihistamines will not be administered by school personnel.

Name of emergency medication: ______________

Dosage: ______________

Physician Signature: ______________

Date: ______________
Day / Month / Year

Anaphylactic Emergency Plan Development - to be completed by the parent / guardian

Have you discussed and reviewed the Anaphylaxis Responsibility Checklist with the school principal?	☐ Yes	☐ No
Have you provided two auto-injectors for the school?	☐ Yes	☐ No
Is your child aware of how to administer the auto-injector?	☐ Yes	☐ No
Does your child carry an auto-injector at all times?	☐ Yes	☐ No

If you answered 'no' for the last question, please state the reason: ______________________________

____

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection of Privacy Act*. School personnel who are exposed to this plan are required to maintain the confidentiality of the student's personal health information. The Board of Education may use your child's personal information for the purpose of:

- Health, safety, treatment and protection
- Emergency care and response

If you have any questions about the collection of your child's personal information, please contact the school principal directly. By signing this form, you give your consent to the Board of Education to disclose your child's personal information to school staff and persons reasonably expected to have supervisory responsibility of school-age students and preschool age children participating in early learning programs (as outlined in the *BC Anaphylactic and Child Safety Framework 2007*) for the above purposes. This consent is valid and in effect until it is revoked in writing by you. If there is a change in your child's condition, it is your responsiblity to advise the school principal of the change and to review this plan promptly.

______________________________ ______________________________

Parent / Guardian Signature *Date (Day / Month / Year)*

Anaphylactic Emergency Plan Development - to be completed by the school principal

Copies of this Anaphylactic Emergency Procedure Plan will be located in the following places:

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____

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____

Location(s) for auto-injectors:

____

____

____

Principal's Signature

____

Date (Day / Month / Year)

Date of Current Plan:

____

Date (Day / Month / Year)

Date for Review:

____

Date (Day / Month / Year)