Dream • Learn • Grow
Bloorview
SCHOOL AUTHORITY

PREVALENT MEDICAL CONDITION — ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name: _______________ Date Of Birth:_______________

OEN: # ______________________ Age: _________ Grade: _________ Weight: _________

Program: IET / RESOURCE Teacher(s):_________________

Student Photo

EMERGENCY CONTACTS (LIST IN PRIORITY)

First contact must be a parent.

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

❒ Food(s): _____________________________ ❒ Insect Stings: _____________________________

❒ Other: ____

Two EpiPens provided by parent:

❒ Carried by child		❒ School office	
Dosage: ❒ EpiPen® Jr. 0.15 mg	❒ Dosage: EpiPen® 0.30 mg	Dosage: ❒ EpiPen® Jr. 0.15 mg	Dosage ❒ EpiPen® 0.30 mg
Expiry Date____________________________		Expiry Date ______________________________	

❒ 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 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: ______________________________

____

BSA EMERGENCY PROCEDURES
(DEALING WITH AN ANAPHYLACTIC REACTION)

ACT QUICKLY. THE FIRST SIGNS OF A REACTION CAN BE MILD, BUT SYMPTOMS CAN WORSEN QUICKLY.

STEPS

1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of a known or suspected anaphylactic reaction.
2. Call Code Blue ext. 5555
3. **Call 9-1-1** Tell them someone is having a life-threatening allergic reaction.
4. Call emergency contact person; e.g., (Parent(s)/Guardian(s).)

HEALTHCARE PROVIDER INFORMATION

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

In addition to EpiPen information listed on page 1.

Healthcare Provider's Name: ____

Profession/Role: ____

Name of other prescribed medication(s) in addition to EpiPen.: ______________________________

Dosage:____________________ Frequency:___________________

Method of administration:____

Possible side effects:____

Special Instructions/Notes/Prescription Labels:____

Healthcare Provider's Signature:_____________________________ Date: __________________

✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

I/we authorize the principal or principal designate to share the Plan of Care with school staff who are in direct contact with my child. For example, the classroom teacher, educational assistants, therapy team, rotary teachers, occasional staff, appropriate Holland Bloorview staff such as Spiral Garden and pool, transportation providers and volunteers.

Other individuals to be contacted regarding Plan of Care:___________________________________

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal if there is a need to change the Plan of Care during the school year.

I/we understand our child's personal health information will be disclosed between organizations to maximize the quality of education being provided to our child and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA).

Parent(s)/Guardian(s): ____________________________________ Date: ____________________

Signature

Principal: ____ Date: ____________________