Add picture of student

ANAPHYLACTIC STUDENT EMERGENCY PROCEDURE PLAN

Parent/Guardian please complete:

Student's Name _____ Date of Birth (Y/M/D) _____

Sex: ☐ Male ☐ Female

Parent/Guardian_____Daytime Phone_____

Emergency Contact_____Daytime Phone_____

Physician_____Daytime Phone_____

Physician please complete:

Physician's Name_____

Daytime Phone_____ Fax_____

Allergen (Do not include antibiotics or other drugs. Please be as specific as possible.)

☐ Peanuts ☐ Nuts ☐ Dairy Other food_____

☐ Spiders ☐ Insects ☐ Latex Any other allergens_____

Symptoms

- 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
- 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_____

Steps for Treating a Severe Allergic Reaction

1. Use the epinephrine auto-injector right away. Give the epinephrine into the muscle of the outer-mid thigh, through clothing if necessary.
2. Call **9-1-1** or the local emergency number.
3. Lie your child down with their legs raised slightly. If they are nauseated or vomiting, lay them on their side. Do not make them sit or stand up. If they are having difficulty breathing, let them sit up.
4. Do not leave your child alone.
5. If your child's symptoms do not get better or get worse, give a second dose of epinephrine as soon as 5 minutes after the first dose.
6. Ensure your child gets to a hospital.

Emergency Medication

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 (Y/M/D)

Parent/Guardian please complete:

Discussed and reviewed Anaphylaxis Responsibility Checklist with principal?	☐ yes	☐ no
Two auto-injectors provided to school?	☐ yes	☐ no
Student aware of how to administer?	☐ yes	☐ no

Auto-injector locations: _____

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection of Privacy Act.* The Board of Education may use your child's personal information for the purposes 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.

_____ _____

Parent/Guardian Signature Date (Y/M/D)

Date Agreed: February 10, 2016
Date Amended:
Date Reviewed:
Related Documents: