

Plan of Care:
ANAPHYLAXIS
School Year: 20__ - 20-__

Student Name	DOB	Gender	Student Photo
Address		Student #	
Exceptionality:	Medic Alert I.D. Yes <input type="checkbox"/> No <input type="checkbox"/>	OEN#	
1.			
2.			
3.	Grade	Age	Teacher(s)

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

SUPPORTS FOR ANAPHYLAXIS
Name of trained individuals who will provide support with anaphylaxis-related tasks: Designated Staff:_____
LHIN Care Workers (if applicable):_____
Method of Home/School Communication:_____
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: _____

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 or local emergency medical services. 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. Go to the nearest hospital immediately (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 (MANDATORY)

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 Instruction/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and the 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

