Limestone DISTRICT SCHOOL BOARD

Form 311 - E - Anaphylaxis Plan of Care

ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Ontario Ed. #: _____ Age: _____

Teacher(s): _____ Grade: _____

Other Medical Condition/Allergies: _____

MedicAlert ID? ☐ Yes ☐ No

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

AUTO-INJECTOR INFORMATION

CHECK THE APPROPRIATE BOXES

☐ Food(s): _____ ☐ Insect Stings:_____

☐ Other: _____

Epinephrine Auto-Injector(s) Expiry Date(s): _____

Dosage: ☐ EpiPen® Jr. t 0.15 mg ☐ EpiPen® 0.30 mg

Medication (Epinephrine Auto-Injectors)
Does the student require assistance to **access**/**administer** auto-injector? ☐ Yes ☐ No

If Yes, auto-injector is kept:
Location: _____ With: _____Other: _____

If No, Student **will carry** their reliever inhaler **at all times** including in the classroom, outside the classroom (e.g. library, cafeteria, recess, gym, etc.) and off-site (e.g. field trips/excursions)
Auto-Injector is kept in the student's:
☐ Backpack/Fanny Pack ☐ Other (specify): _____

Additional auto-injector:
Does the student have an additional auto-injector at schools ☐ Yes ☐ No

If Yes, the additional auto-injector is kept:
Location: _____ With: _____Other: _____

KNOWN LIFE THREATENING TRIGGERS

CHECK THE APPROPRIATE BOXES

☐ 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.

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): (The amount required to cause a reaction varies by person and in some people, it can be triggered by a small amount.)
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: _____

If medication is prescribed and will be administered at school, it is necessary to complete the following documents:

1. Form 314-A1 Physician's Authorization and Request for the Administration of Prescribed Medication
2. Form 314-A3 Authorization and Request for Administration of Epi-Pen, Glucagon, Emergency Seizure Medication

Are forms 314-A1 and Forms 314-A3 required for this student? ☐ Yes ☐ No

TRANSPORTATION		
Plan for Student Transportation		
Individual Student Boarding	Individual Student Securement	Individual Student De-Boarding

Roles

School Staff	Parent/Guardian	Student	Transportation Provider	Operator/Driver
-Create and monitor this plan with parents/guardians, student, TriBoard, and school staff. -Advise TriBoard and parents/guardians of relevant issues while at school during the day. -Help identify tools, or strategies that may help the driver and/or monitor while transporting the student.	-Communicate with the school any medical or other conditions affecting the safe transportation of the student for completion of this plan. -Communicate any changes to any medical or other conditions that might affect transportation. -Communicate with the school and driver any tool or strategies that will help the driver deliver and monitor the needs of the student while transporting them.	-Follow the bus rules and strategies listed on this plan. -Advise the driver of any medical emergency, or health issues that they are experiencing while being transported. -Communicate with the driver if a listed strategy on this plan needs to be addressed or revisited for their comfort (if possible).	-Ensure that all drivers and monitors staffed to transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that transport the student are fully briefed on this plan. -Ensure that proper training of staff is in place regarding boarding, securing, and de-boarding practices to transport student.	-Ensure that the student is transported safety according to needs listed on this plan. -Follow TriBoard and School Board policies and procedures for transporting students with disabilities. -Communicate with school staff and parents/guardians any concerns, or adjustments that need to be made to this plan.

AUTHORIZATION / USE OF INFORMATION / 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: _____

All bus drivers are certified in the administration of First Aid, CPR, and Epi-Pen. These are the only medical procedures a driver may perform. In the event of a student showing signs of medical distress during travel on the school bus, the driver will stop the vehicle in the first safe location, assess the situation, determine if an epi-pen needs to be administered, immediately contact the Bus Operator to request emergency services. The driver will remain with the student until the arrival of the emergency services team. Should a bus driver have occasion to administer First Aid, CPR, or an EpiPen, he/she does so in applying the “in loco parentis” principle, not as a health care professional. Visit triboard.ca for complete procedure details. (Tri-Board)

I consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Limestone District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom ☐ Other: _____

☐ Office

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

☐ Please ***note: Checked box indicates that this student has an additional Plan of Care***