Dufferin-Peel Catholic District School Board

PLAN OF CARE – PREVALENT MEDICAL CONDITION
ANAPHYLAXIS

ONCE COMPLETED, THIS FORM ONLY REQUIRES UPDATING IF THE STUDENT'S MEDICAL CONDITION CHANGES.

Student Information

Student Name: _____

Date of Birth: _____

DPCDSB Student Number: _____

Emergency Contact Information:

Name:	Relationship:	Contact Numbers:

Known Life-Threatening Triggers

Please indicate the nature of the reaction:

Physical – Physical contact with the allergen may cause an anaphylactic reaction
Airborne – Airborne contact with the allergen may cause an anaphylactic reaction
Ingestion – Ingestion contact with the allergen may cause an anaphylactic reaction
All Contact – all of the above may cause an anaphylactic reaction

Allergen(s)	Physical	Airborne	Ingestion	All Contact
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Avoidance of allergen is the main way to prevent an allergic reaction.

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 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 lightheadedness, shock
- **Other:** anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste

Emergency Procedures: Actions to Take: (ACT)

A: Administer the epinephrine immediately when the child displays any of the anaphylactic symptoms

C: Call 911. Notify parents as soon as possible.

T: Transport the child by ambulance to the hospital – even if symptoms subside.

Daily Routine Anaphylaxis Management

TO BE COMPLETED BY MEDICAL PRACTITIONER OR HEALTH CARE PROVIDER

Dosage: ☐ EpiPen Jr 0.15 mg ☐ EpiPen 0.30 mg

Administer epinephrine to (body part): _____

EpiPen will be sent to school: ☐ Yes ☐ No

Storage location(s) of auto-injector(s): _____

Specific directions (e.g., refrigeration, reactions): _____

☐ Student has had a previous anaphylaxis reaction. Therefore, student is at greater risk.
☐ Student has asthma. Therefore, student is at greater risk.

IF STUDENT IS HAVING A REACTION AND HAS DIFFICULTY BREATHING, ***GIVE EPINEPHRINE BEFORE ASTHMA MEDICATION***.

☐ Student has another medical condition and/or allergy: _____

Medical Practitioner/ Healthcare Provider Name: _____ Profession/ Role: _____

Signature: _____ Date: _____

ADMINISTRATIVE/PLAN REVIEW

Individuals with whom this Plan of Care is to be shared:

- ☐ Principal or designate
- ☐ Classroom Teacher(s)
- ☐ Student Monitors/Volunteers
- ☐ Food Services Providers
- ☐ Teacher in Charge
- ☐ Planning Time Teacher(s)
- ☐ Occasional Teachers
- ☐ Administrative Assistant(s)
- ☐ Resource Teacher(s)
- ☐ Support Services

Other individuals to be contacted regarding Plan of Care:

☐ PLASP and/or daycare ☐ Transportation ☐ Other:

Parent and Guardian Acknowledgement and Consent

As the parent of: _____, I have been an active participant in supporting the management of my child's medical condition(s) while they are in school. I understand that the goal of DPCDSB's anaphylaxis policy is to provide a safe environment for my child with a life-threatening allergy, ***but that it is not possible for the school to reduce the risk to zero***.

Teachers and Principals and other school staff are not health professionals and have no more information about the medical condition of my child than what has been provided to them. They are not experts in recognizing the symptoms of my child's medical condition or in treating it.

- ☐ I have educated my child about their medical condition.
- ☐ I have encouraged my child to self-manage and self-advocate.
- ☐ I give consent to share information on signs and/or symptoms with other students (e.g., classmates).
- ☐ I have informed the school of my child's medical condition(s) and will communicate any changes or updates.

This plan remains in effect without change and will be reviewed annually.

It is the responsibility of the parent(s) or guardian(s) to notify the Principal if there is a need to change the Plan of Care.

Parent/ Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Principal Signature: _____ Date: _____