# APPENDIX A: PLAN OF CARE — ANAPHYLAXIS

## STUDENT INFORMATION

| School | Age | Homeroom Teacher | Student Name |
|---|---|---|---|
| | | | |

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Medical ID jewelry ☐ Yes ☐ No

## EMERGENCY CONTACTS (LIST IN PRIORITY)

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

## KNOWN LIFE-THREATENING TRIGGERS

### CHECK (✓) THE APPROPRIATE BOXES

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

☐ Other: _____

Epinephrine auto-injector(s) expiry date(s): _____

Dosage: ☐ EpiPen Jr® 0.15 mg ☐ EpiPen® 0.3 mg ☐ Other _____ Location of Auto-Injector(s): _____ _____

☐ 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? _____

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|---|---|---|---|
| _____ | _____ | _____ | _____ |

## 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, pain or cramps, vomiting, diarrhea.
- **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.

**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: _____

_____

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## 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: _____

Special Instructions/Notes/Prescription Labels:

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

Please select one of the following:

☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.

☐ Only those listed below:

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

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act. R.S.O 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550