<ATTACH PICTURE OF STUDENT>

ANAPHYLAXIS INDIVIDUAL STUDENT EMERGENCY PROCEDURE PLAN

Parent/Guardian please complete	Physician please complete
Student's Name: _____ Date of Birth: _____ (Y/M/D) Sex: □ Male □ Female Parent/Guardian #1: _____ Daytime Phone: _____ Parent/Guardian #2: _____ Daytime Phone: _____ Emergency Contact: _____ Daytime Phone: _____ Physician: _____ Daytime Phone: _____ Care Card # _____	Physician's Name: _____ Daytime Phone: _____ Fax: _____ Allergen: (Do not include antibiotics or other drugs) □ Peanuts □ Nuts □ Dairy □ Other food _____ □ Insects □ Latex □ Other _____ 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: _____
Emergency Protocol • Administer single dose auto-injector and call 911 • Inform dispatcher the child is having a life-threatening anaphylactic reaction • Notify Parent/Guardian • Administer second auto-injector as early as 5 minutes after the first dose is given, if symptoms do not improve or if symptoms recur • Have ambulance transport student to hospital **DO NOT LEAVE THE STUDENT ALONE**	**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)	

Anaphylaxis Individual Student Emergency Procedure Plan

Parent/Guardian please complete

Discussed and reviewed Anaphylaxis procedure and responsibilities with Principal?..... ☐ yes ☐ no

Two auto-injectors provided to school?..... ☐ yes ☐ no

Student is 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 2013*) 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)

Copies to: ☐ Parent(s)/Guardian(s) ☐ Student File ☐ Medical Alert Binder ☐ TTOC file ☐ MyEd

☐ Nursing Support Care Plan (if necessary)