

## School District 42 – Anaphylaxis Individual Student Emergency Procedure Plan

|                           |                                    |                              |
|---------------------------|------------------------------------|------------------------------|
| <b>[Photo I.D.]</b>       | <b>Parent/Guardian to complete</b> |                              |
|                           | _____<br>Student First Name        | _____<br>Student Last Name   |
|                           | _____<br>Date of Birth             | _____<br>Personal Health #   |
|                           | _____<br>Parent/Guardian #1 – Name | _____<br>Daytime Phone #     |
|                           | _____<br>Parent/Guardian #2 – Name | _____<br>Daytime Phone #     |
|                           | _____<br>Emergency Contact – Name  | _____<br>Daytime Phone #     |
| _____<br>Physician – Name |                                    | _____<br>Physician – Phone # |

### Parent/Guardian please complete:

|                                                                                   |                              |                             |
|-----------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Discussed and reviewed Anaphylaxis procedure and responsibilities with Principal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Two auto-injectors provided to school?                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Student is aware of how to administer?                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Your child's personal information is being collected under the authority of the *School Act* and s. 26(c) of the *Freedom of Information and Protection of Privacy Act*. This information is required to ensure health, safety and emergency response, and will be shared with all school staff and persons reasonably expected to have supervisory responsibility, emergency responders and/or health professionals when necessary for safety or care. By signing this form, you consent to the collection, use, and disclosure of your child's personal information for the purposes outlined above. This consent remains valid until revoked in writing. If you have any questions about the collection, use or disclosure of your child's personal information, please contact the school principal or district privacy staff at [privacy@sd42.ca](mailto:privacy@sd42.ca).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date (YYYY-MM-DD)

### KNOWN ALLERGEN(S) [TO BE COMPLETED BY PHYSICIAN OR ALLERGIST ONLY]

- |                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Tree nuts (almonds, Brazil nuts, cashews, hazelnuts, macadamia nuts, pecans, pine nuts, pistachios, walnuts)<br><input type="checkbox"/> Milk<br><input type="checkbox"/> Sesame<br><input type="checkbox"/> Wheat<br><input type="checkbox"/> Fish, e.g. trout, salmon<br><input type="checkbox"/> Mustard<br><input type="checkbox"/> Peanut | <input type="checkbox"/> Egg<br><input type="checkbox"/> Soy<br><input type="checkbox"/> Seafood<br><input type="checkbox"/> Shellfish – Crustaceans (lobster, shrimp, crab- Molluscs, e.g. scallops, clams, oysters, mussels)<br><input type="checkbox"/> Other (List): _____ |
| <input type="checkbox"/> Insect Stings (List): _____                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Medication(s) (List): _____                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Other (e.g. Latex, Pollen) (List): _____                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                |

### SYMPTOMS (TO BE COMPLETED BY PHYSICIAN ONLY):

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <input type="checkbox"/> <b>Skin:</b> hives, swelling (face, lips, tongue), itching, warmth, redness, rash;<br><input type="checkbox"/> <b>Respiratory (breathing):</b> 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;<br><input type="checkbox"/> <b>Gastrointestinal (stomach):</b> nausea, pain/cramps, vomiting, diarrhea;<br><input type="checkbox"/> <b>Cardiovascular (heart):</b> paler than normal skin colour or blue colour, weak pulse, passing out, dizzy/lightheadedness, shock;<br><input type="checkbox"/> <b>Other:</b> anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste. |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

### EMERGENCY MEDICATION (TO BE COMPLETED AND SIGNED BY PHYSICIAN OR ALLERGIST)

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 (YYYY-MM-DD)

**By signing this form annually, I indicate that my child's allergen and emergency medication/dosage, as indicated above by the physician, has stayed the same.**

**I am aware that if my child's medical condition changes in any way, I will need to obtain a new *Anaphylaxis Individual Student Emergency Procedure Plan* signed by the physician.**

|                                                          |                                                       |                            |
|----------------------------------------------------------|-------------------------------------------------------|----------------------------|
| _____<br>Parent/Guardian<br>Printed Name                 | _____<br>Parent/Guardian<br>Signature                 | _____<br>Date (YYYY-MM-DD) |
| _____<br>School Administration (witness)<br>Printed Name | _____<br>School Administration (witness)<br>Signature | _____<br>Date (YYYY-MM-DD) |
| _____<br>Parent/Guardian<br>Printed Name                 | _____<br>Parent/Guardian<br>Signature                 | _____<br>Date (YYYY-MM-DD) |
| _____<br>School Administration (witness)<br>Printed Name | _____<br>School Administration (witness)<br>Signature | _____<br>Date (YYYY-MM-DD) |
| _____<br>Parent/Guardian<br>Printed Name                 | _____<br>Parent/Guardian<br>Signature                 | _____<br>Date (YYYY-MM-DD) |
| _____<br>School Administration (witness)<br>Printed Name | _____<br>School Administration (witness)<br>Signature | _____<br>Date (YYYY-MM-DD) |
| _____<br>Parent/Guardian<br>Printed Name                 | _____<br>Parent/Guardian<br>Signature                 | _____<br>Date (YYYY-MM-DD) |
| _____<br>School Administration (witness)<br>Printed Name | _____<br>School Administration (witness)<br>Signature | _____<br>Date (YYYY-MM-DD) |
| _____<br>Parent/Guardian<br>Printed Name                 | _____<br>Parent/Guardian<br>Signature                 | _____<br>Date (YYYY-MM-DD) |
| _____<br>School Administration (witness)<br>Printed Name | _____<br>School Administration (witness)<br>Signature | _____<br>Date (YYYY-MM-DD) |
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