CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

2755 Highway 43, Kemptville, Ontario K0G 1J0
phone: 613-258-7757 toll free: 1-800-443-4562
www.cdsbeo.on.ca

ANAPHYLAXIS
Plan of Care (Sample)

Student Information

Student Name: _____ DOB: _____

OEN: _____ Age: _____

Grade: _____ Teacher(s): _____

Medical ID Jewelry ☐ Yes ☐ No

Student Photo (Optional)

Emergency Contacts (List in Priority)

Name	Relationship	Daytime Phone	Alternate Phone
1.			
2.			
3.			

Known Life-Threatening Inducers

Check (✓) the Appropriate Boxes

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

☐ Other: _____

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

Dosage: ☐ EpiPen Jr® 0.15mg ☐ EpiPen® 0.3mg

☐ 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 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 induced by a small amount.

Food(s) to be avoided: _____

Safety measures: _____

_____

Other information: _____

_____

_____

Medication (Epinephrine auto-injectors):

Access to epinephrine auto-injector:
Student requires assistance to access their auto-injector? ☐ Yes ☐ No
If yes, auto-injector is kept:

Location: _____ With: _____ Other: _____

If no, student carry their auto-injector at all times: in the classroom, outside the classroom (e.g., library, cafeteria/lunchroom, gym) and off-site (e.g., field trips/ excursions).

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Auto-injector in student's
☐ Backpack/fanny pack
☐ Other

Additional auto-injector:
The student has an additional auto-injector at school? ☐ Yes ☐ No
If yes, the additional auto-injector is kept:

Location: _____ With: _____ Other: _____

Emergency Procedures (Dealing with 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 911. 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. Student to remain in the hospital for an appropriate period of observation as decided by the emergency department physician.
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: _____

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. ***

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Authorization 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: _____

This plan remains in effect for the _____ - _____ 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

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature