PEN #

BOARD OF EDUCATION
BURNABY
SCHOOL DISTRICT 41

Form A

ANAPHYLAXIS
Emergency Action Plan
Refer to Medical Information Form

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

Student Name | Birthdate: year/month/day | Parent/Guardian Name

Parent/Guardian Home Phone # | Parent/Guardian Business Phone #

Emergency Contact Name/Phone # | Physician Name/Phone #

Check the appropriate boxes:

☐ Peanut ☐ Tree Nuts ☐ Medication: _____

☐ Egg ☐ Milk ☐

☐ Insect Sting ☐ Latex ☐ Other: _____

Food: People with food allergies should not share food or eat unmarked/bulk foods or products with a 'may contain' warning.

Epinephrine Auto-Injector: **Expiry Date:** _____

Dosage: ☐ EpiPen Jr® 0.15 mg ☐ EpiPen® 0.30 mg

Location of Auto-Injector(s): _____
(or person will carry his/her own medication)

☐ **Asthmatic:** Person is at greater risk. **If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.**

A person having an anaphylactic reaction might have ANY of these signs or symptoms:

Skin: hives, swelling, itching, warmth, redness, rash.
Respiratory (breathing): wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain or 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.

Early recognition of symptoms and immediate treatment could save a person's life. Act quickly.

The first signs of a reaction can be mild, but symptoms can get worse very quickly.

EMERGENCY TREATMENT PLAN:

1. **Give epinephrine auto-injector** (e.g. EpiPen® or Twinject™) at the first sign of a reaction occurring in conjunction with a known or suspected contact with allergen. Give a second dose in 10 to 15 minutes or sooner **IF** the reaction continues or worsens.
2. **Call 911**. Tell them someone is having a life-threatening allergic reaction. Ask them to send an ambulance immediately.
3. **Go to the nearest hospital**, even if symptoms are mild or have stopped. Stay in the hospital for an appropriate period of observation, generally 4 hours, but at the discretion of the ER physician. The reaction could return.
4. **Call contact person**.

This form must be kept in the School Office "Medical Alert Section" for reference.

ANAPHYLAXIS EMERGENCY ACTION PLAN

For:_____

Student Name

This Anaphylaxis Emergency Plan has been developed to assist schools in supporting students who are at risk for allergic reactions while attending school.

Physician Authorization

The student's physician must complete the following information and sign this plan. The student's anaphylaxis triggers are (please check)

☐ peanuts ☐ nuts ☐ milk ☐ all dairy ☐ eggs ☐ shellfish ☐ fish

when food is: ingested ☐ touched ☐ smelled ☐

☐ food additives (list) _____ ☐ insect stings (list) _____

☐ medications (list)_____ ☐ others (list) _____

speed of reaction: _____

Emergency Medication

Please note that the emergency medication must be a single-dose, single use auto-injector EpiPen®.

Name of emergency medication_____ Dosage_____

Physicians' Name: _____

Signature of Physician: _____ Date Signed: _____

Parent/Guardian Authorization

The parent/guardian of the above named student must check the following information and sign this plan.

☐ I authorize the staff of the Burnaby School District and its agents to administer the designated treatment and to obtain suitable medical assistance.

☐ I have provided the school with Physician's instruction and signature.

☐ I have discussed and reviewed Anaphylaxis responsibility checklist with principal/designate.

☐ I have provided the school with a single dose auto-injector EpiPen®(s).

☐ My child can administer the EpiPen ®.

Auto-injector school location _____

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection 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 the school staff and persons reasonably expected to have supervisory responsibility of school-aged students and preschool age children participating in early learning programs for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

Parent/Guardian Signature: _____ **Date Completed:** _____

This agreement must be reviewed at the beginning of every school year and when changes occur.

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s) _____ School Health Resource Binder (red binder)_____
Nursing Support Care Plan (if necessary) _____Student's Emergency Kit