School District 42 – Anaphylaxis Individual Student Emergency Procedure Plan

[Photo I.D.]

Parent/Guardian to complete

Student First Name	Student Last Name
Date of Birth	Personal Health #
Parent/Guardian #1 – Name	Daytime Phone #
Parent/Guardian #2 – Name	Daytime Phone #
Emergency Contact – Name	Daytime Phone #
Physician – Name	Physician – Phone #

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

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.

Parent/Guardian Signature _____ Date (YYYY-MM-DD) _____

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

☐ Tree nuts (almonds, Brazil nuts, cashews, hazelnuts, macadamia nuts, pecans, pine nuts, pistachios, walnuts)
☐ Milk ☐ Egg
☐ Sesame ☐ Soy
☐ Wheat ☐ Seafood
☐ Fish, e.g. trout, salmon ☐ Shellfish – Crustaceans (lobster, shrimp, crab- Molluscs, e.g. scallops, clams, oysters, mussels)
☐ Mustard
☐ Peanut ☐ Other (List): _____

☐ Insect Stings (List): _____

☐ Medication(s) (List): _____

☐ Other (e.g. Latex, Pollen) (List): _____

SYMPTOMS (TO BE COMPLETED BY PHYSICIAN ONLY):

☐ **Skin:** hives, swelling (face, lips, tongue), 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):** paler than normal skin colour or blue colour, weak pulse, passing out, dizzy/lightheadedness, shock;
☐ **Other:** 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) _____