New Westminster Schools

INSERT STUDENT PHOTO HERE

ANAPHYLAXIS INDIVIDUAL STUDENT EMERGENCY PROCEDURE PLAN

EMERGENCY CONTACT INFORMATION (Parent/Guardian please complete)	
Student's Name:	**School:**
Care Card #:	**Birthdate:**
Address:	
Parent/Guardian #1:	
Phone #1:	**Phone #2:**
Parent/Guardian #2:	
Phone #1:	**Phone #2:**
Emergency Contact:	
Phone #1:	**Phone #2:**
Family Physician:	
Physician Daytime Phone:	**Physician Fax:**

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 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 2007) 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)**

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TO BE COMPLETED BY PHYSICIAN - ALLERGEN(S):

☐ **Peanuts** ☐ **Nuts** ☐ **Dairy** ☐ **Insects** ☐ **Latex** ☐ **Other**:_____

Symptoms: Check all that apply

Skin - ☐ Hives ☐ Swelling ☐ Itching ☐ Warmth ☐ Redness/flush ☐ Rash

Respiratory - ☐ Wheezing ☐ Shortness of breath ☐ Throat tightness ☐ Cough ☐ Hoarse voice
(breathing)

☐ Chest pain/tightness ☐ Trouble swallowing ☐ Nasal congestion (runny itchy nose, watery eyes, sneezing)

Gastrointestinal - ☐ Nausea ☐ Pain/cramps ☐ Vomiting ☐ Diarrhea
(stomach)

Cardiovascular - ☐ Pale/blue colour ☐ Weak pulse ☐ Dizzy/lightheaded ☐ Loss of consciousness
(heart)

☐ Shock ☐ Confusion

Other - ☐ Anxiety ☐ Feeling of "impending doom" ☐ Headache ☐ Uterine cramps

Additional symptoms: _____

_____

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:_____

EMERGENCY PROTOCOL:

☐ Administer single dose auto-injector and call 911

☐ Inform dispatcher the child is having a life- threatening anaphylactic reaction

☐ Notify Parent/Guardian

☐ If symptoms do not improve or if they recur, administer second auto-injector; 5 to 15 minutes after the first dose is given

☐ Have ambulance transport student to hospital

DO NOT LEAVE THE STUDENT ALONE

_____ _____

Physician Signature **Date (YYYY/MM/DD)**

Copies: ☐ **Student File** ☐ **Medical Alert Binder** ☐ **Educator in Charge/TTOC File**
☐ **EA Float book** ☐ **My Education BC** ☐ **Parent(s)/Guardian(s)**