



Anaphylactic Student Emergency Procedure Plan

School District No. 73 (Kamloops-Thompson)



Parent/Guardian please complete	Physician please complete
<p>Student's Name: _____</p> <p>Date of Birth: _____ (Y/M/D)</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Parent/Guardian: _____</p> <p>Daytime Phone: _____</p> <p>Emergency Contact: _____</p> <p>Daytime Phone: _____</p> <p>Physician: _____</p> <p>Daytime Phone: _____</p>	<p>Physician's Name: _____</p> <p>Daytime Phone: _____</p> <p>Fax: _____</p> <p>Allergen: (Do not include antibiotics or other drugs)</p> <p><input type="checkbox"/> Peanuts <input type="checkbox"/> Nuts <input type="checkbox"/> Dairy <input type="checkbox"/> Other food</p> <p>_____</p> <p><input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Other</p> <p>_____</p> <p>Symptoms:</p> <ul style="list-style-type: none">• Skin – hives, swelling, 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): pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock• Other: anxiety, feeling of "impending doom", headache, uterine cramps in females <p>Additional symptoms: _____</p> <p>_____</p>
<p>Emergency Protocol</p> <ul style="list-style-type: none">• Administer single dose auto-injector and call 911• Notify Parent/Guardian• Administer second auto-injector as early as 5 minutes after the first dose is given, if symptoms do not improve or if symptoms recur• Have ambulance transport student to hospital <p>_____</p> <p>Physician Signature</p>	<p>Emergency Medication</p> <p>NOTE: Emergency medication must be a single-dose auto-injector for school setting. Oral antihistamines will not be administered by school personnel.</p> <p>Name of emergency medication: _____</p> <p>Dosage: _____</p> <p>_____</p> <p>Date (Y/M/D)</p>

Parent/Guardian please complete

Discussed and reviewed Anaphylaxis Responsibility Checklist with principal?..... yes no

Two auto-injectors provided to school?..... yes no

Student aware of how to administer?..... yes no

Auto-injector locations:

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)