Allergy/Anaphylaxis Forms 2020-2021

Please fill in these forms and return to the school the first week of September. Please include any EpiPens that are needed. Students are encouraged to wear one EpiPen on their person in a pouch and have a second EpiPen located in the office. Please include a recent colour photo of your child.

Appendix A

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

ANNUAL PARENT/GUARDIAN REQUEST AND CONSENT FOR ALLERGY/ ANAPHYLAXIS INTERVENTION

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ANAPHYLACTIC REACTION

To Be Completed by Parent/Guardian Annually

(Please Print or Type)

Demographic Information

Student's Name: ___________________________________ Birthdate: Month ____ Day __ Year _______

Administration of Medication

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel, however I authorize the administration of an epinephrine auto-injector, as prescribed by the attending physician/nurse practitioner, in the event that my child, __________________________ ___________________ experiences an anaphylactic reaction on school property or during a school or school board sponsored event. I also understand that my child may need to be held in order to administer the epinephrine auto-injector and consent to same.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: Month _____ Day __ Year ______

Principal Signature: ____

Self-Administration of Medication

I consent to my child _______________________________________ carrying an epinephrine auto-injector on her/his person.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: Month ________ Day ___ Year _______

Principal Signature: ____

I consent to my child ____ self-administering the epinephrine auto-injector prescribed by the attending physician/nurse practitioner, if physically capable.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: Month ________ Day ___ Year _______

Principal Signature: _______________________________________

Posting of Photographs and Individual Allergy/Anaphylaxis Plan of Care

I consent to the posting of photographs of my child ____

and of medical information related to my child (Individual Allergy/Anaphylaxis Action Plan) in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: Month ________ Day ___ Year _______

Principal's Signature: _____________________________________

Consent to the Development of an Individual Allergy/ Anaphylaxis Plan of Care

I consent to the development of an Individual Allergy/ Anaphylaxis Plan of Care for my child________________________________. This plan will outline the emergency steps that shall be taken if my child experiences an anaphylactic reaction on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Date: Month ________ Day ___ Year _______

Principal's Signature: _____________________________________

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in main office)

This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.

Appendix B

Hamilton-Wentworth Catholic District School Board

PHYSICIAN/NURSE PRACTITIONER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ANAPHYLACTIC REACTION

Complete When The School is First Informed of Condition or if the Condition Changes

To be completed by Attending Physician/ Nurse Practitioner

(Please Print or Type)

Demographic Information

Student's Name: ____________________________________

Birthdate: Month ________________________ Day___________ Year ______________

Ontario Education Number (OEN): ____

Description of Allergy

Foods, products, substances etc. which are to be avoided:

Description of Symptoms of Allergic Reaction

- ☐ Cardiovascular System (Heart) ____
- ☐ Gastrointestinal System (Stomach) ____
- ☐ Respiratory System (Breathing) ____
- ☐ Skin System ____
- ☐ Other ____

Medical Certification

This is to certify that ________________________________ has a potentially life-threatening
(name)

allergy to _______________________________ and must be given an epinephrine auto-injector in the event of an anaphylactic reaction.

Dosage:

- ☐ Epipen ® Jr. 0.15 mg
- ☐ Epipen ® 0.30 mg

Possible side-effects of medication administration: ____

Additional medications which may be administered after the epinephrine auto-injector include:

____

(Physician/Nurse Practitioner Authorization to be completed only when information is new or has changed)

Physician/ Nurse Practitioner Name: ______________________ *Telephone:* ________________

Physician/ Nurse Practitioner Signature: _________________________________

Date: Month ___________ *Day* ____________ *Year* _______________

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in Main Office)

This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.

Appendix C

Hamilton-Wentworth Catholic District School Board

INDIVIDUAL ALLERGY/ ANAPHYLAXIS PLAN OF CARE

STUDENT INFORMATION		
Student Name	Date of Birth	Coloured Student Photo
Grade	Teacher(s)	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS		
CHECK (✓) THE APPROPRIATE BOXES		
❒ Food(s):		❒ Insect Stings:
❒ Other:		
Epinephrine Auto-Injector(s) Expiry Date (s): **Expired Medication will be returned to the parent/guardian/adult student**.		
Dosage: ❒ EpiPen® Jr. 0.15 mg	❒ EpiPen® 0.30 mg	
Medication Location #1 (on the student):		Medication Location #2:
❒ 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 conditions or allergies?		

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, vomiting, diarrhea, pain or cramps.
	Cardiovascular system (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or lightheadedness, 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.
Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.
Food(s) to be avoided:
Safety measures:
Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where stinging insects nest or congregate. Destroy or remove nests, cover or move trash cans, keep food indoors.)
Designated eating area inside school building
Safety measures:
Other information:
EMERGENCY PROCEDURES (DEALING WITH AN ANAPHYLACTIC REACTION)
STEPS
1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of known or suspected anaphylactic reaction.
2. Call 9-1-1 or local emergency medical services. 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. Go to the nearest hospital immediately (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 — 6 hours).
5. Call emergency contact person; e.g. Parent(s)/Guardian(s).
6.
7.
8.
9.
10.

Refer to Appendix P for the Board Policy on Allergic Reactions (Anaphylaxis Awareness)

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 on the Physician/nurse practitioner Authorization Form. ✸This information may remain on file if there are no changes to the student's medical condition.	

AUTHORIZATION/PLAN REVIEW			
INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED			
		Yes (Please Initial for each)	No (Please Initial for each)
We the Parents/Guardians consent to the carrying of an epinephrine auto-injector on her/his person.			
We the Parents/Guardians consent to the self-administration of medication.			
We the Parents/Guardians consent to the administration of medication.			
We, the Parents/Guardians request the posting of this Individual Plan of Care, including recent colour photo in the:	School Staff Room		
	Elementary Homeroom Classroom		
	School Main Office		
We the Parents/Guardians request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, volunteers, and school bus drivers.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care with students in the classroom.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care through a letter home to families of students in the classroom.			
We, the Parents/Guardians request the sharing of this Individual Plan of Care with the Before and After-School Program.			
TRANSPORTATION			
School Bus Driver/Route # (If Applicable)		☐ New Plan of Care	☐Updated Plan of Care

This plan remains in effect for the 20___— 20___ 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).

Signature	Date
Parent(s)/Guardian(s) Signature :	Date:
Adult Student Signature:	Date:
Principal Signature:	Date: