School District No. 43 (Coquitlam)

# ANAPHYLAXIS EMERGENCY ACTION PLAN

Child's Name: _____ Date of Birth: _____

(Photo I.D.)

Parent/Guardian: _____

Home # _____ Work# _____

Emergency Contact: _____ Home # _____

Work # _____ Physician & Phone # _____

This form is requested to provide a detailed action plan for your child

*My child's anaphylaxis triggers are:*

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

Food additives (list): _____

Insect stings (list): _____

Medications (list): _____

Others (list): _____

*My Child's anaphylaxis symptoms are usually:*

| | | |
|---|---|---|
| ☐ swelling (eyes, lips, face, tongue) | ☐ nausea or vomiting | Others (list): |
| ☐ difficulty breathing or swallowing | ☐ coughing or choking | |
| ☐ hives | ☐ stomach cramps, diarrhea | |
| ☐ fainting or loss of consciousness | ☐ dizziness, confusion | |

## My child's emergency treatment is:

1. Give EpiPen Location of EpiPen: _____
2. Call 911 and tell the dispatcher that a child is having a life-threatening anaphylactic reaction.
3. Call the parent, guardian or emergency contact person.

*DO NOT LEAVE THE STUDENT ALONE*

(OVER)

Student Name: _____

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**Authorization** (Initial those that apply)

I agree to:

_____ supply the school with medications and up-to-date Epi-pen(s).

_____ provide The Child with a medic alert bracelet and fanny-pack for Epi-pen.

_____ ensure The Child knows his/her responsibilities for his/her own safety

_____ ensure The Child will have an Epi-pen on their person. (It is strongly recommended that children have Epi-pens on their person at all times.)

_____ I understand that my failure to do the above may result in an inability to implement timely emergency procedures for this potential life threatening condition.

_____ I authorize the staff of School District No. 43 and its agents, including volunteers, to execute the school's commitments as outlined within this plan.

_____ I am aware that the Public Health Nurse for the school will be informed of my child's condition and treatment and that the nurse may contact me as necessary.

_____ I give consent for the identification of The Child as a person with _____ (nature of condition/risk). I understand that this may include the display of pertinent information, including a picture of The Child in strategic locations within the school. It is understood that the reason for this display is to enable the staff of School District No. 43 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.

_____ I authorize the staff of School District No. 43 and its agents to administer the designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve the staff of School District No. 43 and the Coquitlam School Board of the responsibility for any adverse reactions resulting from the administration of the designated medication.

_____ If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information as needed.

This agreement is valid from the date signed until revoked.

Parent/Guardian signature: _____ Date completed: _____

Date completed: _____

| Copies to: | Parent(s) | Student File | Medical Alert Binder | Nursing Support Care Plan (if necessary) |
|---|---|---|---|---|
| | TOC File | Child's Fanny Pack | | |

*This Anaphylaxis Emergency Action Plan has been collaboratively developed by Public Health and School District No. 43 (Coquitlam).*
*The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy act.*