**APPENDIX 2**

**TEMPLATE**

## DURHAM DISTRICT SCHOOL BOARD

# INDIVIDUAL STUDENT ALLERGY MANAGEMENT PLAN

**Place student's picture here**

**Student Name:** _____

**Date of Birth:** _____

**School:** _____

**Teacher:** _____

**Classroom(s):** _____

**Grade:** _____

# ANAPHYLAXIS EMERGENCY PLAN

**Place student's picture here**

**Student Name:** _____

**Teacher(s) Classroom (s):** _____

**This student has a life-threatening allergy to the following:**

Strict avoidance of the allergen(s) by the student is critical to their well-being. An anaphylactic reaction can proceed quickly and prove fatal within minutes.

| **Epinephrine Auto-injector(s)** | | **MedicAlert® Identification** |
|---|---|---|
| ☐ **EpiPen Jr® 0.15mg** | ☐ **EpiPen® 0.30mg** | ☐ **Yes** ☐ **No** |
| ☐ **Allerject ™ 0.15mg** | ☐ **Allerject ™ 0.30mg** | |

**Location(s) of Auto-injector(s):** _____

☐ **Asthmatic**: Student is at greater risk. If student is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication

**Early recognition of symptoms and immediate treatment could save a person's life**

- **A person having an anaphylactic reaction might have ANY of these signs and symptoms: Think F.A.S.T.**

**Face**: itchiness, redness, rash, swelling of face and tongue
**Airway**: trouble breathing, swallowing or speaking
**Stomach**: stomach pain, vomiting, diarrhea
**Total Body**: rash, itchiness, swelling, weakness, paleness, sense of doom, loss of consciousness

**A.C.T. quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.**

1. **Administer epinephrine** auto-injector at the first sign of a reaction occurring in conjunction with a known or suspected contact with an allergen. Give second dose in 10-15 minutes or sooner **IF** the reaction continues or worsens.
2. **Call 911**. Tell them someone is having a serious allergic reaction/anaphylactic.
3. **Transport to hospital** by ambulance even if symptoms are mild or have stopped.
4. **Call the parent(s)/guardian(s)/emergency contact**.

**PHYSICIAN INSTRUCTIONS**

**Student Name:** **Parent(s)/Guardian(s) Name:**

**Address: Street** **City** **Postal Code**

**1) Does this patient have a known predisposition to anaphylaxis?_____**

**2) What medication is to be administered in the event of an anaphylactic reaction?**
**_____**

**Name of Medication** **Dose or amount to be given: _____** **Total doses or times per event: _____**
**_____**

**Additional Instructions:**

**_____** **_____**
**Prescribing Physician Name:** **Signature:**
**_____**
**Date:**

**Address: Street** **City** **Postal Code** **Phone Number**

**PRE-AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION**

**I hereby pre-authorize and give permission for, _____**
**Name of School**

**to administer medication to my child in the event of an anaphylactic reaction, according to the Board's policies and procedures and the physician's prescription and instructions as described within this individual student plan.**

**_____**
**Parent(s)/Guardian(s) Signature** **Date**

**_____**
**Student's Signature** **Date**

**Student Name**: _____

| | |
|---|---|
| **Type of Allergy and Details for Informing Employees** | _____<br>_____<br>_____ |
| **Monitoring Strategies** | _____<br>_____<br>_____ |
| **Avoidance Strategies** | _____<br>_____<br>_____ |
| **Appropriate Treatment** | _____<br>_____<br>_____ |
| **Emergency Procedure** | _____<br>_____<br>_____ |

**Location of student's additional epinephrine auto-injector(s):**

**Expiry Date(s) for epinephrine auto-injectors:**

**Monitoring Schedule** (Checking auto-injector in student's possession):

□ Once per term □ Once per semester

□ Dates of Monitoring Check: _____

□ Person Monitoring: _____

**Student Name:**_____

**Contingencies for Excursions:**
(Including but not limited to: field trips, off-site sporting events etc.)

☐ Establishing parent/designate who may stay with student
☐ Ensuring at least two (2) epinephrine auto-injectors are available
☐ Ensuring that staff has immediate access to a telephone/cell phone
☐ Other:

**Emergency Contact Information:**

| Name | Relationship | Home Phone | Work Phone | Cell Phone |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Parent(s)/Guardian(s) Signature Date

Student's Signature Date

Principal/Designate Signature Date

**NOTE: THIS PLAN MUST BE REVIEWED BY THE PARENT AND PRINCIPAL BY JUNE 30TH OF EACH YEAR. UPDATED PHYSICIAN NOTES ARE ONLY REQUIRED IF THE INSTRUCTIONS FOR TREATMENT HAVE CHANGED.**