PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

ANAPHYLAXIS EMERGENCY ACTION PLAN (FORM 1A)

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

_____

Student Name BD year/month/day Parent/Guardian Name

_____ _____

Parent/Guardian Home Phone # Parent/Guardian Business Phone #

_____ _____

Emergency Contact Name/Phone # Physician Name/Phone #

My child's anaphylaxis triggers are:

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

food additives (list) _____

when food is: ingested ☐ touched ☐ smelled ☐

insect stings (list) _____

medications (list)_____

others (list) _____

speed of reaction: _____

My child's anaphylaxis symptoms are usually:

☐ **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, 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

MY CHILD'S EMERGENCY TREATMENT IS:

1. **Administer 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.**
4. **Have ambulance transport student to hospital.**

DO NOT LEAVE THE STUDENT ALONE

This form must be kept in the School Health Resource Binder (red binder) "Medical Alert Section"

ANAPHYLAXIS EMERGENCY ACTION PLAN For:

_____

Student name

This Anaphylaxis Emergency Plan has been developed to assist schools in supporting students who are at risk for allergic reactions while attending school.

Physician Authorization

The student's physician must complete the following information and sign this plan. The student's anaphlaxis triggers are (please check)

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

when food is: ingested ☐ touched ☐ smelled ☐

☐ food additives (list) _____ ☐ insect stings (list) _____

☐ medications (list)_____☐ others (list) _____

speed of reaction: _____

Emergency Medication

Please note that the emergency medication must be a single-dose, single use auto-injector Epipen.

Name of emergency medication _____

Dosage _____

Physician name: _____

Signature of Physician: _____ Date Signed: _____

Parent/Guardian Authorization

The parent/guardian of the above named student must check the following information and sign this plan.

☐ I authorize the staff of the Burnaby School District and its agents to administer the designated treatment and to obtain suitable medical assistance.

☐ I have provided the school with Physician's instruction and signature.

☐ I have discussed and reviewed Anaphylaxis responsibility checklist with principal/designate.

☐ I have provided the school with a single dose auto-injector Epipen(s).

☐ My child can administer the Epipen.

Auto-injector school location _____

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection 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 the school staff and persons reasonably expected to have supervisory responsibility of school-aged students and preschool age children participating in early learning programs for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

Parent/Guardian Signature: _____ Date Completed: _____

This agreement must be reviewed at the beginning of every school year and when changes occur.

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s) _____ School Health Resource Binder (red binder)_____
Nursing Support Care Plan (if necessary) _____Student's Emergency Kit