Anaphylactic Student Emergency Procedure Plan

Mission Public Schools

PARENT/ GUARDIAN TO COMPLETE:

Student's Name: _____
(Last Name) (First Name) (Middle Name)

Parent/ Guardian: _____
(Last Name) (First Name) (Daytime Phone #)

Emergency Contact: _____
(Last Name) (First Name) (Daytime Phone #)

PHYSICIAN TO COMPLETE:

Physician: _____
(Name) (Daytime Phone #) (Fax #)

Allergen: (Do not include antibiotics or other drugs)

☐ Peanuts ☐ Nuts ☐ Dairy Other food:_____
☐ Insects ☐ Latex ☐ Other:_____

Symptoms:

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

Additional Symptoms:_____

Emergency Protocol

- Administer single dose auto-injector and call 911
- Notify the Parent/Guardian
- Administer the second auto-injector as early as 5 minutes after the first dose is given, if symptoms do not improve or if symptoms recur
- Have an ambulance transport student to the hospital

Emergency Medication

NOTE: Emergency medication must be a single-dose auto-injector for a school setting. Oral antihistamines will not be administered by school personnel.

Name of Medication: _____
Dosage:_____
Physician Signature:_____ Date:_____
DD/MM/YEAR

PARENT/ GUARDIAN TO 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:_____

Personal information is collected by Mission Public Schools under ***Section 26*** *of the Freedom of Information and Protection of Privacy Act and for the purpose of health, emergency care, and treatment response. If you have questions about this form, or the collection and use of this information, contact the* school principal or call *School District No. 75, Tel: 604-826-6286 and speak to the Privacy Coordinator.* By signing this form, you give your consent to the school district to disclose your child's personal information to school staff and persons reasonably expected to have supervisory responsibility for school-age students and preschool-age children participating in school district programs for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

Parent/ Guardian Signature: _____ Date: _____