

EXTREME ALLERGY MANAGEMENT and EMERGENCY PLAN

SCHOOL YEAR 2 _____ -2 _____

PART I – STUDENT INFORMATION

Name of Student: _____ Date of Birth: _____
Year / Month / Day

Medicare Number: _____

School: _____ Home room teacher: _____

Parent / Guardian: _____

Phone: _____ (home) _____ (work) _____ (cell)

Other contact: _____
(i.e. caregiver)

Phone: _____ (home) _____ (work) _____ (cell)

Physician: _____ Phone: _____

What type of EpiPen® (epinephrine) does this child require? Regular (66 lbs. or more)
 Junior (between 33 lbs. and 66 lbs.)

Allergy Information (to be completed by student's physician)

Anaphylaxis (Anaphylactic shock) is a severe allergic reaction that can involve several body systems and lead to death if left untreated. Anaphylaxis can result from reactions to foods, insect stings, medications, latex and other substances. The most common food triggers of anaphylaxis are peanut, tree nuts, shellfish, fish, milk, egg, wheat, soy and sesame. However, a wide variety of other foods and exercise have been known to trigger anaphylaxis. Trace amounts of an allergen can trigger a severe reaction.

Child at risk of anaphylactic reaction? Yes No

If yes, to what? _____

Any other significant allergies? Yes No

If yes, describe _____

EpiPen® (epinephrine) recommended? Yes No

Physician _____
signature

Date: _____
year / month / day

**Appendix D
EXTREME ALLERGY MANAGEMENT
and EMERGENCY PLAN**

Student: _____

PART II – EXTREME ALLERGY MANAGEMENT PLAN

This part is to be completed by the school in collaboration with the parent.

Parent's responsibilities: _____

PART II

School's responsibilities: _____

Student's responsibilities: _____

**Appendix D
EXTREME ALLERGY MANAGEMENT
and EMERGENCY PLAN**

Student: _____

PART III – EMERGENCY PLAN

This part is to be completed by the school in collaboration with the parent. (eg. administer EpiPen®; call an ambulance or drive to hospital; contact parents).

Parent's responsibilities: _____

PART III

- I agree to have relevant information about my child's health/medical condition posted in strategic areas of the school (e.g. classroom, cafeteria, library, staff room) to assist staff in providing emergency services to my child. I will provide a photo of my child for this purpose.
- I do not wish information about my child to be posted in the school.

School's responsibilities: _____

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Student: _____

PART IV – SIGN-OFF

I have read and understand the *Extreme Allergy Management and Emergency Plan* and agree to the sharing of information relevant to the service requested with those persons who must know in order to provide the service.

Student (16 years and older): _____ **Date:** _____
signature year / month / day

I hereby request and authorize school personnel to provide the care described above to my child. I understand school personnel have no medical qualifications and will perform the requested service in good faith and within the scope of the training received in accordance with this agreement.

In the event of an emergency, I authorize school personnel to administer the medication specified in this agreement and to obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and transportation.

I understand the school cannot guarantee an environment that is 100% allergen free.

I hereby acknowledge my responsibilities, as set out in this agreement and in Policy 704 - *Health Support Services*, and agree to carry these out to the best of my ability.

I agree to notify the school in writing of any changes to the information provided on this form.

I agree that the information provided on this form will be shared on a need-to-know basis with anyone who will be involved in the care of my child on behalf of the school.

I agree that the principal may contact my child's physician if he/she has questions: Yes No

Parent/Guardian: _____ **Date:** _____
signature year / month / day

I hereby acknowledge and accept my responsibilities and those of my staff, as set out in this agreement.

Principal: _____ **Date:** _____
signature year / month / day

PART IV

**Appendix D
EXTREME ALLERGY MANAGEMENT
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Student: _____

ANNUAL REVIEW

Note: if the requirements of the service requested have changed, complete a new *Extreme Allergy Management and Emergency Plan* form. If no changes, use this sign-off sheet to confirm plan has been reviewed with the parent.

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day