PREVALENT MEDICAL CONDITION ANAPHYLAXIS
PLAN OF CARE

STUDENT INFORMATION		Student Photo
STUDENT NAME:		
Student wears Medical-Alert Bracelet YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ **I consent to publicly displaying this photo.**

EMERGENCY CONTACTS in ORDER

Name	Relationship	Phone #
1.		
2.		
3.		
4.		

MEDICATION

Has medication been prescribed to manage this condition? Yes No
Has emergency recovery medication been prescribed? Yes No

If yes, this plan must be shared with your physician and the following section (appendix A) must be completed by a physician.
NCCSA AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care?
Yes No

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Diabetes
- ☐ Concussion
- ☐ General: _____

STUDENT NAME:

KNOWN LIFE-THREATENING TRIGGERS (check all that apply)

☐ **FOOD to be AVOIDED**	☐ **INSECT STINGS**	☐ **OTHER**
LIST: ☐ ☐ ☐ ☐	LIST: ☐ ☐ ☐ ☐	LIST: ☐ ☐ ☐ ☐
SAFETY MEASURES:	**SAFETY MEASURES:** ☐ Avoid areas where stinging insects next or congregate. ☐ Report, remove or destroy nests ☐ Remove or cover trash bins ☐ Keep food indoors	**SAFETY MEASURES:** ☐ If child has ASTHMA give Epipen before inhaler

MEDICATION

Two EPIPens Provided by Parent **Child is at a greater risk if:** ☐ **Has ASTHMA Give epipen before asthma medication** ☐ **Has had PREVIOUS anaphylactic reaction**	**Carried By Child** ☐ Dosage Epipen Jr or ☐ Dosage Epipen **Carried by** ☐ Fanny Pack ☐ Leg Strap ☐ Back Pack	**School Office** ☐ Dosage Epipen Jr or ☐ Dosage Epipen **Exact Location:**
	EXPIRY DATE:	**EXPIRY DATE:**

NCCSA EMERGENCY PROCEDURES FOR ANAPHYLACTIC REACTIONS

EARLY RECOGNITION OF SYMPTOMS AND IMMEDIATE TREATMENT COULD SAVE A LIFE
A person with an anaphylaxis reaction could have one or more of the following:

SKIN SYMPTOMS ☐ **Hives** ☐ **Swelling** ☐ **Face** ☐ **Lips** ☐ **Tongue** ☐ **Itching** ☐ **Redness** **OTHER** ☐ **Anxiety** ☐ **Sense of doom** ☐ **Headache** ☐ **Uterine cramps** ☐ **Metallic taste**	**RESPIRATORY SYSTEM** ☐ **Coughing** ☐ **Wheezing** ☐ **Shortness of breath** ☐ **Chest pain or tightness** ☐ **Throat tightness** ☐ **Hoarse voice** ☐ **Nasal congestion** ☐ **Runny itchy nose** ☐ **Watery eyes** ☐ **Sneezing** ☐ **Trouble swallowing**	**GASTROINTESTINAL SYSTEM** ☐ **Nausea** ☐ **Vomiting** ☐ **Diarrhea** ☐ **Pain Cramps** **CARDIOVASCULAR SYSTEM** ☐ **Paler than normal skin** ☐ **Blue Skin** ☐ **Weak pulse** ☐ **Passing out** ☐ **Dizziness** ☐ **Lightheadedness** ☐ **Shock**

STUDENT NAME:

- ☐ **GIVE EPINEPHRINE AUTO INJECTOR** (eg. EpiPen or Allerject) at the first sign of a known or suspected anaphylactic reaction.
  - ☐ Note time
  - ☐ Monitor reaction
- ☐ **CALL 911 or local medical services.**
  - ☐ Tell them someone is having a life-threatening allergic reaction.
  - ☐ Follow guidance.
- ☐ **CALL Emergency Contact Person**
- ☐ **GIVE SECOND DOSE of EPINEPHRINE** as early as five minutes after the first dose if there is no improvement in symptoms.
- ☐ **GO TO NEAREST HOSPITAL IMMEDIATELY (ideally by ambulance)**
  - ☐ Even If symptoms are mild or have stopped
  - ☐ The reaction can worsen or come back even after proper treatment.
  - ☐ Stay in hospital for an appropriate period of observation as decided by the emergency department physician.

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we are aware that the school will share this Plan of Care with:**
  - ☐ **Niagara Children's Centre**
  - ☐ **Nursing (if applicable)**
  - ☐ **Transportation Provider**

This plan of care remains in effect for the _____ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date:

Appendix A

niagara children's centre school Weaving education and therapy together for student success.
AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION
TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		

HEALTH CARE PROVIDER INFORMATION
Please review the NCCSA Plan of Care with your healthcare provider.

Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		

Name of Medication	
DATE	
Date prescribed	
Dosage to be provided each time	
Times dosage to be provided	
Method of administration	
Possible side effects	
Storage and safekeeping s	

PARENT/GUARDIAN APPROVAL
I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA procedures and the instructions provided.
I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Health Care Provider **Optional** UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: