

## MEDICAL ALERT INFO & CARE PLAN (Allergies/Anaphylaxis)

*To be completed when the school agrees with the parental request to administer medication. To be reviewed annually. A new form must be completed if medication changes. This form is to be filed at the school.*

<b>A. To be completed by the parent</b>			
Student Name (Last Name, First Name)	D.O.B. (dd/month/year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Student #
Address	City/ Province	Postal Code	Personal Health Card #
Student Home Phone #	MedicAlert® I.D. <input type="checkbox"/> Yes <input type="checkbox"/> No	Teacher	Grade Div Classroom #
Name of Father	Home Phone #	Business #	
Name of Mother	Home Phone #	Business #	
Name of Guardian	Home Phone #	Business #	
Emergency Contact Person	Relationship to Student	Phone #	
Alternate Contact Person	Relationship to Student	Phone #	
<b>B. To be completed by the attending physician / family doctor</b>			
For medication which MUST be taken during school hours or during school sponsored events (Instructions re storage of medication for refrigeration) <b>If more than 1 medication, please see reverse for more space.</b>			
Allergy Description: <input type="checkbox"/> Food: Food(s) Allergic to: _____ <input type="checkbox"/> Insect Sting (specify): _____ <input type="checkbox"/> Other: _____			
Symptoms to Watch For: (Please check) <input type="checkbox"/> itchy eyes, nose, face, body <input type="checkbox"/> flushing/redness/warmth of face and body <input type="checkbox"/> swelling of eyes, face, lips, tongue and throat (throat tightness), trouble swallowing <input type="checkbox"/> nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing) <input type="checkbox"/> cough, hoarse voice, inability to breathe <input type="checkbox"/> hives/rash <input type="checkbox"/> headache, nausea, pain/cramps, vomiting, diarrhoea, uterine cramps in females <input type="checkbox"/> wheezing, shortness of breath, chest pain/tightness <input type="checkbox"/> anxiety, a feeling of foreboding, fear, and apprehension <input type="checkbox"/> weakness and dizziness/light-headedness, pale blue colour, weak pulse, shock <input type="checkbox"/> loss of consciousness, coma <input type="checkbox"/> Other: _____			
Name of Medication: <input type="checkbox"/> EpiPen® auto-injector <input type="checkbox"/> Other: _____			Expiry Date:
Reason for Medication:			
Method of Administration (Dosage, time of administration):			Self Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Instructions:			
What is the impact of a missed dose?			
Name of Physician (please print)	Signature of Physician	Date	Phone #

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### C. Other Medications: To be completed by the attending physician / family doctor

For medication which **MUST** be taken during school hours or during school sponsored events  
(Instructions re storage of medication for refrigeration, etc.)

Allergy Description:  Food: Food(s) Allergic to: \_\_\_\_\_  
 Insect Sting (specify): \_\_\_\_\_  Other: \_\_\_\_\_

**Symptoms to Watch For:** (Please check)

- itchy eyes, nose, face, body
- flushing/redness/warmth of face and body
- swelling of eyes, face, lips, tongue and throat (throat tightness), trouble swallowing
- nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing)
- cough, hoarse voice, inability to breathe
- hives/rash
- headache, nausea, pain/cramps, vomiting, diarrhoea, uterine cramps in females
- wheezing, shortness of breath, chest pain/tightness
- anxiety, a feeling of foreboding, fear, and apprehension
- weakness and dizziness/light-headedness, pale blue colour, weak pulse, shock
- loss of consciousness, coma
- Other: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Method of Administration (Dosage, time of administration) \_\_\_\_\_ Self Administered  
 Yes  No

Additional Instructions \_\_\_\_\_

What is the impact of a missed dose? \_\_\_\_\_

Name of Physician (please print) _____	Signature of Physician _____	Date _____	Phone # _____
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### D. To be completed by the parent / guardian

Initials \_\_\_\_\_

- \_\_\_\_\_ I am aware of Board Policy and Regulation on the Treatment of Students with a Known Risk of Anaphylaxis/Life Threatening Allergies.
- \_\_\_\_\_ I agree that the above information is correct.
- \_\_\_\_\_ If changes occur I will contact the school and provide revised instructions.
- \_\_\_\_\_ I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's directions for use, including dosage.
- \_\_\_\_\_ I am aware that no medication will be administered until this form is completed and returned.
- \_\_\_\_\_ I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- \_\_\_\_\_ I am aware that staff working with my child may need to know of my child's condition and of the medication required.
- \_\_\_\_\_ I am aware I am required to update this information each September.

I authorize and request the administration of the above medication from \_\_\_\_\_ to \_\_\_\_\_.

I will provide the medication in the original container with expiration date, labelled by a pharmacist.

\_\_\_\_\_ \_\_\_\_\_  
*Signature of Parent / Guardian* *Date*

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### TO BE COMPLETED BY SCHOOL

#### E. To be completed by the principal or designate

Staff designated to supervise/administer medication

Alternate(s)

Location of Medication in the School

\_\_\_\_\_  
Name of Principal or Designate (please print)

\_\_\_\_\_  
Signature of Principal or Designate

\_\_\_\_\_  
Date


#### F. Training Documentation

Date of Training / Review	Name of Trainer

#### G. Procedures to deal with a problem: - Allergies / Anaphylaxis

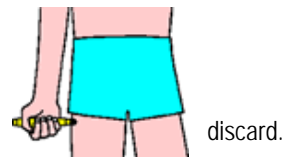
If you see symptoms of a severe allergic reaction or know that a child has eaten something they are allergic to:

1. **Administer the EpiPen®** – Don't hesitate. It can be life saving.

- i. Pull off grey safety cap 

- ii. Push black tip into outer thigh  
If necessary may be done through light or single layer of clothing (no thicker than jeans)

- iii. Listen for a "Click". Hold for 10 seconds. Remove and



- iv. **If symptoms persist or recur**, a second dose can be administered in 10 to 20 minutes. (*maximum 3 doses*).

2. **Have someone call 911.** Tell them that a student has had an anaphylactic reaction. Give them: Name and address of school (use 911 protocol).
3. The student should rest quietly. **DO NOT SEND THE CHILD TO THE OFFICE.**
4. Help the student to remain calm and to breathe normally. **An adult must stay with the student.**
5. Call the parents/guardians/emergency contact.
6. Observe and monitor the student until the ambulance arrives.