

(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month ____ Day __ Year _____

Administration of Medication

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel, however I authorize the administration of an epinephrine auto-injector, as prescribed by the attending physician/nurse practitioner, in the event that my child, _____ experiences an anaphylactic reaction on school property or during a school or school board sponsored event. I also understand that my child may need to be held in order to administer the epinephrine auto-injector and consent to same.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month ____ Day __ Year _____

Principal Signature: _____

Self-Administration of Medication

I consent to my child _____ carrying an epinephrine auto-injector on her/his person.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month ____ Day __ Year _____

Principal Signature: _____

I consent to my child _____ self-administering the epinephrine auto-injector prescribed by the attending physician/nurse practitioner, if physically capable.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month ____ Day __ Year _____

Principal Signature: _____

Posting of Photographs and Individual Allergy/Anaphylaxis Plan of Care

I consent to the posting of photographs of my child _____
and of medical information related to my child (Individual Allergy/Anaphylaxis Action Plan) in locations
deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource
room, school bus, staff room and other locations.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

Consent to the Development of an Individual Allergy/ Anaphylaxis Plan of Care

I consent to the development of an Individual Allergy/ Anaphylaxis Plan of Care for my
child _____. This plan will outline the emergency steps that shall be taken if
my child experiences an anaphylactic reaction on school property or during a school or school board
sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's
protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers,
occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus
drivers.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in main office)

*This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of
Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.*

Hamilton-Wentworth Catholic District School Board
PHYSICIAN/NURSE PRACTITIONER AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION FOR ANAPHYLACTIC REACTION

Complete When The School is First Informed of Condition or if the Condition Changes

To be completed by Attending Physician/ Nurse Practitioner
(Please Print or Type)

Demographic Information

Student's Name: _____

Birthdate: Month _____ Day _____ Year _____

Ontario Education Number (OEN): _____

Description of Allergy

Foods, products, substances etc. which are to be avoided:

Description of Symptoms of Allergic Reaction

- Cardiovascular System (Heart) _____
- Gastrointestinal System (Stomach) _____
- Respiratory System (Breathing) _____
- Skin System _____
- Other _____

Medical Certification

This is to certify that _____ has a potentially life-threatening
(name)
allergy to _____ and must be given an epinephrine auto-injector in the
event of an anaphylactic reaction.

Dosage:

- Epipen ® Jr. 0.15 mg
- Epipen ® 0.30 mg

Possible side-effects of medication administration: _____

Additional medications which may be administered after the epinephrine auto-injector include:

(Physician/Nurse Practitioner Authorization to be completed only when information is new or has changed)

Physician/ Nurse Practitioner Name: _____ Telephone: _____

Physician/ Nurse Practitioner Signature: _____

Date: Month _____ Day _____ Year _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in Main Office)

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INDIVIDUAL ALLERGY/ ANAPHYLAXIS PLAN OF CARE



STUDENT INFORMATION		Coloured Student Photo
Student Name	Date of Birth	
Grade	Teacher(s)	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS	
CHECK (ü) THE APPROPRIATE BOXES	
r Food(s):	r Insect Stings:
r Other:	
Epinephrine Auto-Injector(s) Expiry Date (s): Expired Medication will be returned to the parent/guardian/adult student.	
Dosage: r EpiPen® Jr. 0.15 mg	r EpiPen® 0.30 mg
Medication Location #1 (on the student):	Medication Location #2:
r Previous anaphylactic reaction: Student is at greater risk.	
r Has asthma. Student is at greater risk. If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.	
r Any other medical conditions or allergies?	

DAILY/ROUTINE ANAPHYLAXIS MANAGEMENT	
SYMPTOMS: A student having an anaphylactic reaction might have any of these signs and symptoms:	
	Skin system: hives, swelling (face, lips, tongue), itching, warmth, redness.
	Respiratory system (breathing): coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.
	Gastrointestinal system (stomach): nausea, vomiting, diarrhea, pain or cramps.
	Cardiovascular system (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or lightheadedness, shock.
	Other: anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste.

EARLY RECOGNITION OF SYMPTOMS AND IMMEDIATE TREATMENT COULD SAVE A PERSON'S LIFE.	
Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.	
Food(s) to be avoided:	
Safety measures:	
Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where stinging insects nest or congregate. Destroy or remove nests, cover or move trash cans, keep food indoors.)	
Designated eating area inside school building	
Safety measures:	
Other information:	
EMERGENCY PROCEDURES (DEALING WITH AN ANAPHYLACTIC REACTION)	
STEPS	
1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of known or suspected anaphylactic reaction.	
2. Call 9-1-1 or local emergency medical services. Tell them someone is having a life-threatening allergic reaction.	
3. Give a second dose of epinephrine as early as five (5) minutes after the first dose if there is no improvement in symptoms.	
4. Go to the nearest hospital immediately (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 — 6 hours).	
5. Call emergency contact person; e.g. Parent(s)/Guardian(s).	
6.	
7.	
8.	
9.	
10.	

Refer to Appendix P for the Board Policy on Allergic Reactions (Anaphylaxis Awareness)

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)	
Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.	
Healthcare Provider's Name:	
Profession/Role:	
Signature:	Date:
Special Instructions/Notes/Prescription Labels:	
If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects on the Physician/nurse practitioner Authorization Form. -This information may remain on file if there are no changes to the student's medical condition.	

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

		Yes (Please Initial for each)	No (Please Initial for each)
We the Parents/Guardians consent to the carrying of an epinephrine auto-injector on her/his person.			
We the Parents/Guardians consent to the self-administration of medication.			
We the Parents/Guardians consent to the administration of medication.			
We, the Parents/Guardians request the posting of this Individual Plan of Care, including recent colour photo in the:	School Staff Room		
	Elementary Homeroom Classroom		
	School Main Office		
We the Parents/Guardians request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, volunteers, and school bus drivers.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care with students in the classroom.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care through a letter home to families of students in the classroom.			
We, the Parents/Guardians request the sharing of this Individual Plan of Care with the Before and After-School Program.			

TRANSPORTATION

School Bus Driver/Route # (If Applicable) New Plan of Care Updated Plan of Care

This plan remains in effect for the 20__ — 20__ school year without change and will be reviewed on or before:
 _____ . (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s) Signature :	Date:
Adult Student Signature:	Date:
Principal Signature:	Date:

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD



**INDIVIDUAL ALLERGY/ANAPHYLAXIS
ACCOMMODATION PLAN**

STUDENT: _____ SCHOOL: _____

GRADE: _____ CLASSROOM(S): _____

TEACHER(S): _____

INSTRUCTIONS

When a student, who is at risk of having an anaphylactic reaction to an allergen registers at an elementary school of the Board, the Individual Allergy/Anaphylaxis Accommodation Plan and the Individual Allergy/Anaphylaxis Plan of Care shall be completed by the principal in order to manage the risk of an anaphylactic reaction. The principal/designate shall utilize the medical documentation provided by the parent/guardian in order to complete those Plans.

1.0 ALLERGENS

This student has been diagnosed as being at risk of having an anaphylactic reaction to the following allergens: [Check applicable box(es)]

- Corn
- Dairy
- Eggs
- Fish
- Insect Stings
- Latex
- Mustard
- Peanuts

- Sesame
- Shellfish
- Soy
- Sulphites
- Tree Nuts
- Wheat
- Other (Please Specify)

2.0 DESIGNATED ALLERGEN – AWARE AREAS

The areas of the School campus where foods or substances, which contain the identified allergens are not permitted to be eaten include the following: [Check applicable box(es)]

- | | |
|---|--|
| <input type="checkbox"/> School Auditorium(s) | <input type="checkbox"/> Student's Homeroom (Room # _____) |
| <input type="checkbox"/> School Cafeteria(s) | <input type="checkbox"/> Designated Area in Student's Homeroom _____ |
| <input type="checkbox"/> School Gymnasium(s) | <input type="checkbox"/> Other Classrooms & Labs (Room # _____) |
| <input type="checkbox"/> School Hallways | <input type="checkbox"/> Other (Please specify) _____ |
| <input type="checkbox"/> School Library | <input type="checkbox"/> _____ |
| <input type="checkbox"/> School Main Office | <input type="checkbox"/> _____ |
| <input type="checkbox"/> School Playground | <input type="checkbox"/> _____ |

These areas of the School shall be identified through the use of signage displayed prominently on the doors to each specific area indicating "ALLERGEN AWARE AREA" along with a list of restricted allergens (e.g. Dairy, Eggs, Peanuts, etc.).

3.0 ALLERGEN MANAGEMENT STRATEGIES

It is the responsibility of the HWCDSB to ensure that staff members who work within the HWCDSB schools and buildings, receive annual anaphylaxis training. The following "Allergen Management Strategies" shall be implemented to manage the risk of an anaphylactic reaction : [Check applicable box(es)]

3.1 Management Strategies in Identified Student's Classroom

- Daily monitoring by staff of classmates' lunch/snack containers for identified allergens.
- Student with identified allergen to consume food in alternate, designated area.
- Provision of allergen aware lunches/snacks for students who bring allergens to the identified student's Homeroom.
- Hand-washing before and after eating (all students).
- Sanitizing of identified student's lunch table before eating and sanitizing of all students' lunch tables after eating.
- Identified student eats only food prepared at home or approved for consumption by parent/guardian.
- No sharing of food, food containers or utensils by any students.

- Food for special events in the classroom is prepared by parent/guardian of identified student or by allergen aware commercial producer.
- Provision of non-edible items for special events in the classroom (e.g. prizes, stickers etc.).
- Inspection of curricular materials for presence of identified allergens (e.g. Play-Doh).

3.2 Management Strategies in the School

- Identified student has Epinephrine Auto-Injector on her/his person.
- Food for special events in the School is purchased from an allergen aware commercial producer.
- School fund-raising activities avoid including products containing identified allergens.
- All musical instruments that have a mouth piece are sanitized before and after use.
- Any musical instrument used by an identified student is sanitized before and after use.
- Computer keyboard used by the identified student is sanitized before use.
- Wet wipes will be available in applicable classrooms. In applicable classrooms, all students will be encouraged to wash their hands using a wet wipe after eating and before exiting their classroom and entering common areas of the School.
- Implementation of additional physician/nurse practitioner recommended management strategies to the extent possible.
- Other (Please specify): _____

4.0 SUPPLY TEACHERS, SUPPLY E.C.E. TEACHERS AND SUPPLY EDUCATIONAL ASSISTANTS

It is the responsibility of the HWCDSB to ensure that staff members who work as supply staff within the HWCDSB schools and buildings, receive annual anaphylaxis training. Staff members who are placed temporarily in the identified student's classroom shall receive the following preparation prior to beginning their assignment:

- Training in the use of the Epinephrine Auto-Injector.
- Provision of the *Individual Allergy/Anaphylaxis Accommodation Plan* and the *Allergy/Anaphylaxis Plan of Care* for each identified student.
- Other (Please specify): _____

5.0 SCHOOL BUS PROCEDURES

The HWCDSB will ensure that those school bus companies secured to provide student bus service to HWCDSB students, will provide annual anaphylaxis training for their school bus drivers. If the identified student takes a school bus to and/or from school or is transported on a school bus for a field trip, the following procedures shall be implemented:

- Food and drinks are not to be consumed on the school bus.
- Training is provided for the school bus driver in the use of the Epinephrine Auto-Injector.
- Provision of the Individual Allergy/Anaphylaxis Accommodation Plan and the Individual Allergy/Anaphylaxis Plan of Care for each identified student to the School Bus Company.
- School Bus Driver has access to telephone, cell phone or radio communication in case of an emergency.
- Identified student has Epinephrine Auto-Injector on her/his person.
- Identified student has a designated seat near the School Bus Driver.
- Other (Please specify): _____

6.0 FIELD TRIP PROCEDURES

If the identified student participates in a field trip authorized by the School the following procedures shall be implemented:

- A field trip supervisor, trained in the administration of Epinephrine Auto-Injector is assigned to the identified student.
- Provision of the Individual Allergy/Anaphylaxis Accommodation Plan and the Allergy/Anaphylaxis Plan of Care to field trip supervisors.
- Field trip supervisor has access to telephone/cell phone in case of an emergency.
- Provision of two (2) Epinephrine Auto-Injectors in case of an emergency.
- Identified student has Epinephrine Auto-Injector on her/his person.
- Other (Please specify): _____

7.0 ACCESS TO THE INDIVIDUAL ALLERGY/ANAPHYLAXIS ACCOMMODATION PLAN

Copies of this Individual Allergy/Anaphylaxis Accommodation Plan will be kept in the Office and in the identified student's classroom. It will be accessible to the principal, the principal's designate, the identified student's teacher, and other teachers and staff as necessary. Individuals with whom the plan may be shared include, but are not limited to classroom teachers, lunch and recess supervisors, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

8. PRINCIPAL AUTHORIZATION

Principal's Signature: _____

Date: ___/___/___

D M Y

The personal information contained in this document is collected, used and disclosed pursuant to and in compliance with the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M-56 and the *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sched. A.