Checklist for Parents
of an Anaphylactic Student

□ arrange meeting with principal to exchange information

□ notify school personnel of your child's allergens in order of severities

□ provide the school with a recent photograph of your child if they do not have one

□ complete *The Student Emergency Procedure Plan*

□ complete *The Request for Administration of Medication at School Form*

□ provide the school with required number of Epi-Pens and make sure they are not expired

□ consider a Medic Alert ® bracelet for your child

□ educate yourself about foods that can cause anaphylactic reactions

□ stress with your child and the school staff that only foods from home are to be eaten

□ keep up-to-date about education and new information in this field

□ research field trip sites for allergen risks

□ verify all posted information about your child

□ inform school staff of any allergic reactions that occur outside of school hours

STUDENT EMERGENCY PROCEDURE PLAN
Re: ALLERGY ALERT INFORMATION - EPI-PEN

Picture of Student

STUDENT NAME _____

ADDRESS _____

HOME PHONE _____

PARENT/GUARDIAN WORK PHONE _____

PARENT/GUARDIAN WORK PHONE _____

PARENT/GUARDIAN CELL PHONE _____

PARENT/GUARDIAN CELL PHONE _____

ALTERNATE EMERGENCY CONTACT PERSON _____

ALTERNATE EMERGENCY CONTACT PHONE _____

TEACHER _____

CLASS/GRADE _____ **ROOM #** _____

CARE CARD # _____

PHYSICIAN _____ **PHYSICIAN'S TELEPHONE**

ALLERGY-DESCRIPTION: This child has a **DANGEROUS**, life threatening allergy to the following items and to all foods containing them in any form in any amount (list items on line below):

_____

AVOIDANCE: The key to preventing an emergency is **ABSOLUTE AVOIDANCE** of these foods at all times. **WITHOUT AN EPI-PEN THIS CHILD MUST NOT BE ALLOWED TO EAT ANYTHING THAT THEY DID NOT BRING THEMSELVES FROM HOME or WITHOUT THE CONSENT OF THE PARENTS/GUARDIANS.**

EATING RULES: *(List eating rules for child, if any, in this space)*

POSSIBLE SYMPTOMS:

□ Flushed face, hives, swelling or itchy lips, tongue, eyes
□ Difficulty breathing or swallowing, wheezing, coughing, choking
□ Dizziness, unsteadiness, sudden fatigue, rapid heartbeat
□ Other _____
□ Tightness in throat, mouth, chest
□ Vomiting, nausea, diarrhea, stomach pains
□ Loss of consciousness

ACTION – EMERGENCY PLAN: At any sign of difficulty (e.g. hives, swelling, difficulty breathing):

□ Administer **EPI-PEN** immediately
□ Call 9-1-1
□ Call parent/guardian
□ Administer second Epi-Pen, within 10-15 minutes, or sooner, if symptoms do not improve
□ (Even if symptoms subside entirely, this child **must** be transported to a hospital immediately)
□ One person stays with child at all time; one person goes for help or calls for help.

EPI-PENS® are kept in _____ Classroom/lunchroom/staff room/office/with student
Expiry date on Epi-Pen:_____

I agree to this information being placed in key areas around the school:
Parent/Guardian signature: _____

REQUEST FOR ADMINISTRATION
OF MEDICATION AT SCHOOL FORM

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name	**Birthdate (Year, Month, Day)**	
Parent or Guardian	**Home Phone**	**Business/Cell Phone**
Physician	**Phone**	

B. ATTACH A DUPLICATE PHARMACY LABEL OF PRESCRIBED MEDICATION
OR
REQUEST THAT THE PRESCRIBING PHYSICIAN COMPLETE THE FOLLOWING:
Conditions Which Make Medication Necessary

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		

Additional Comments (possible Reactions, Consequences of Missing Medication, Etc.)	
If prescribing epinephrine emergency medication, it must be a single dose, single-use auto-injector for school setting with a second injector, if parents have provided a second injector, which can be given 10-15 minutes if symptoms do not improve. An oral antihistamine will not be administered by school personnel.	**Physician's Signature** _____ **Date**

Additional information can be provided on reverse side.

C. TO BE COMPLETED BY PARENT OR GUARDIAN
I request the school to give medication as prescribed to my child whose name is recorded below
Name of Child: _____

Date: _____

I will Notify the School Promptly of Any Changes in Medications Ordered

Signature of Parent or Guardian: _____

Additional information can be provided on reverse side.

D. EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OR SUPERVISION OF THE MEDICATION MUST REVIEW THE INFORMATION ON THIS CARD THEN DATE AND SIGN BELOW

Date	Signature	Comments, If Any

The information collected will be used for educational program purposes and when required, may be provided to health services, social services or other support services as required by law. The information collected on this form will be protected under the Protection of Information Privacy Act (PIPA). Questions about the collection and use of this information should be directed to the principal of your school or to the Superintendent of Island Catholic Schools, Victoria, B.C., (250) 727-6893.

Additional Information: