Supplementary Document (Anaphylaxis)

To be used in addition to the **Anaphylaxis Emergency Plan** when the anaphylaxis allergen is **food** and additional special provisions are needed at school.

If changes to any part of this plan are required, please complete a new form (including consent and authorization signatures) and share with all involved.

IDENTIFICATION

Student's name:

School name:

Date of birth (mm/dd/yyyy):

Health card number:

MedicAlert number: ☐ N/A

Does the student carry an Emergency Health Services (EHS) Special Patient Protocol card? ☐ Yes ☐ No

If yes, what is the Special Patient Protocol card number:

Allergies:

☐ Food
☐ Insect stings
☐ Other; please specify:

Medical diagnosis(es):

Place Photo Here

Is the student aware of their diagnosis? ☐ Yes ☐ No

Does the student experience fears and/or anxiety related to their health care needs/medical diagnosis(es)?

☐ Yes ☐ No *If yes*, please describe helpful coaching/support/management strategies:

Medications required during school hours: ☐ N/A

1.
2.
3.

Location where medication is stored at the school (refer to the Regional Centre for Education's policy):

1.
2.
3.

Does the student have any activity restrictions while at school? ☐ Yes ☐ No *If yes,* please describe:

Bus Driver Name(s) and Bus Number(s)	
Morning bus: ☐ N/A	Afternoon bus: ☐ N/A
The bus driver(s) and/or school designated person(s) providing transportation have been notified by the school principal (or designate) of student's medical diagnosis. ☐ Yes ☐ N/A	

Emergency Contacts—*Please prioritize (1, 2, 3) in the order the calls are to be placed.*		
1. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:
2. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:
3. Name: Relationship:	Home phone: Work phone: Cell phone:	Email:

Non-emergency Preferred Method of Communication	
☐ Phone call	☐ Communication book/agenda
☐ Text	☐ Email
☐ Other; please specify:	
Additional information:	

Designated School Staff with Training (*to be completed by school staff*)	
1.	4.
2.	5.
3.	6.

ALLERGIES

Identify food(s) the student avoids:

- ☐ Seafood
  - ☐ Fish (e.g., trout, salmon)
  - ☐ Shellfish
    - – crustaceans (e.g., lobster, shrimp, crab)
    - – molluscs (e.g., scallops, clams, oysters, mussels
- ☐ Egg
- ☐ Milk
- ☐ Other; please specify:
- ☐ Mustard
- ☐ Peanuts
- ☐ Sesame
- ☐ Soy
- ☐ Tree Nuts (almonds, Brazil nuts, cashews, hazelnuts, macadamia nuts, pecans, pine nuts, pistachios, walnuts)
- ☐ Wheat

Anaphylaxis Emergency Plan attached and on file: ☐ Yes

Note: This is a requirement; please refer to your Regional Centre for Education's policy.

GOALS AND RESPONSIBILITIES

1. The goal in school, and the shared responsibility of staff, parents/guardians, students, and the entire school community, is to minimize exposure and to be allergy aware.
2. Anaphylaxis teaching, including emergency response using epinephrine auto-injectors, must be done with all staff annually and as needed (follow your Regional Centre for Education's policy). This includes substitute teachers.
3. All procedures should remain in place, even when the food-allergic student is absent from school.
4. Soap and water is recommended for hand washing in order to rid the skin of the protein that causes anaphylaxis when ingested. There is evidence* that certain antibacterial wipes can be as effective as soap and water (e.g., Lysol® sanitizing wipes, Clorox® disinfecting wipes). Alcohol-based sanitizer and water alone is not effective in removing protein residue from the skin.

*Perry, T., Conover-Walker, M.K., Pomés, A., Chapman, M., Wood, R.A., 2004. "Distribution of Peanut Allergen in the Environment." *Journal of Allergy and Clinical Immunology*, 113(5), 973–976.

MEAL/SNACK PLAN

The student can eat among their peers: ☐ Yes ☐ No

If no, or if special instructions are required, please specify the plan (the meal/snack plan should be done in collaboration with the school principal):

AVOIDANCE STRATEGIES

Identify the avoidance strategies that must be in place:

- ☐ Avoid food in the classroom, when possible (e.g., meals, snacks, activities that include food). Principals will discuss options for meal/snack time locations on an individual basis.
- ☐ The student should place their meals on a napkin or designated placemat.
- ☐ The student should eat in a designated "allergy aware" area while at school to help minimize the risk of cross-contamination. If applicable, principals will discuss on an individual basis.
- ☐ Specific cleaning of surfaces and floors within rooms where contaminating food is consumed and the student will be.
- ☐ Supervision during meal/snack times by someone who has anaphylaxis training and knows how to use an epinephrine auto-injector.
- ☐ Specific hand-washing routines for the student (before and after eating, and as needed).
- ☐ Specific hand-washing routines for staff and students (before entering the classroom, after eating, and as needed).
- ☐ No sharing or trading of food.
- ☐ Other; please specify:

EPINEPHRINE AUTO-INJECTOR

Identify the brand of epinephrine auto-injector used by the student: ☐ EpiPen® ☐ Other; please specify:

The student's auto-injector is stored: ☐ on their person

☐ other; please specify (e.g., in their backpack):

Note: It is recommended that students carry the epinephrine auto-injector with them at all times to ensure timely response. Please refer to the Regional Centre for Education's policy requirement regarding the location of the epinephrine auto-injector.

HIVES

Does the student typically get hives on their skin? ☐ Yes ☐ No

If yes, complete the section below.

External symptoms	Actions: Steps in Order
External symptoms can/may include • the presence of hives on the skin • pinkish/reddish swollen lesions with pale centres • lesions that may be itchy	If external symptoms *only* are reported by the student, or are observed, call the parent(s)/guardian(s) immediately and follow their directions, or please specify:
Internal symptoms	**Actions: Steps in Order**
Internal symptoms can/may include • swelling of the lips and tongue • itchy mouth, tongue, and/or throat • throat tightness, hoarse voice • hacking cough, repeated cough, choking • trouble swallowing and/or speaking • trouble breathing, shortness of breath, wheezing • vomiting, nausea, stomach pain, diarrhea • feeling dizzy, unsteady gait, feeling drowsy, feeling a sense of doom, feeling faint, or fainting	If internal symptoms are occurring with the hives (or without) give EPINEPHRINE AUTO-INJECTOR and follow the **attached Anaphylaxis Emergency Plan** from Food Allergy Canada.

PARENT/GUARDIAN (STUDENT, IF APPROPRIATE) CONSENT

Release of Plan of Care Information

I agree with the plan of care outlined in this document. I am aware that school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith.

I understand that it is my responsibility to notify my child's principal if there is a need to change or cancel this plan during the school year. If I wish to change or cancel this plan, I will do so in writing.

I authorize school staff to share information from this plan for purposes related to the education, health, and safety of my child. This may include

- displaying my child's picture in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of my child's medical condition
- placing a copy of this plan in appropriate locations in the school and storing an electronic copy in the Nova Scotia Student Information System
- communicating with school bus drivers or other designated persons who may be transporting my child
- any other sharing of information that may be necessary to protect the health and safety of my child

______________________________ ______________________________
Parent/Guardian Signature mm/dd/yyyy

______________________________ ______________________________
Student Signature (if appropriate) mm/dd/yyyy

AUTHORIZATIONS

My name below indicates that I have reviewed and am in agreement with the information contained in this Plan of Care and when needed have been in contact with the authorized prescriber and/or other regulated health care provider(s) for clarification and verification as indicated below.

______________________________ ______________________________
Regulated Health Care Professional Signature mm/dd/yyyy

______________________________ ______________________________
Print Name Print Designation

As applicable, name of authorized prescriber and/or regulated health care provider and date of contact:

____

______________________________ ______________________________
Principal Signature mm/dd/yyyy

____
Print Name

The signature of the SHP Nurse below indicates involvement in the development of this plan.

______________________________ ______________________________
School Health Partnership (SHP) Nurse Signature (when applicable) mm/dd/yyyy

____
Print Name

PLAN OF CARE EFFECTIVE DATE

This plan is effective as of ______________________________. *Note: Plans of care must be reviewed, updated, and signed annually.*
mm/dd/yyyy