YORK CATHOLIC DISTRICT SCHOOL BOARD

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Board Form	Board Form No.
Student Services	S.15-206
Classification	Retention
STU 45	C + 1
Approved Date	Revision Date
	June 2026

ANAPHYLAXIS PLAN OF CARE & CONSENT FORM

ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Date Created _____ Bus Route/# _____

Student Name _____ Date Of Birth _____

Age _____ School _____

Grade _____ Teacher(s) _____

Medical ID Jewellery ☐ Yes ☐ No

Insert Photo

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

☐ Food(s): _____ ☐ Insect Stings: _____

☐ Other: _____

Epinephrine auto-injector(s) or nasal spray(s) expiry date(s): _____

Dosage: ☐ EpiPen Jr® 0.15 mg ☐ EpiPen® 0.3 mg ☐ neffy® 2.0 mg

☐ Previous anaphylactic reaction: **Student is at greater risk.**

☐ Has asthma. **Student is at greater risk**. If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.

Any other medical condition or allergy? _____

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, pain or cramps, vomiting, diarrhea.
- **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.

Avoidance of an allergen is the main way to prevent an allergic reaction.

Food Allergen(s): (The amount required to cause a reaction varies by person and in some people, it can be triggered by a small amount.)

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: _____

MEDICATION (Epinephrine auto-injectors or nasal sprays):

Access to epinephrine auto-injector or nasal spray:
Student requires assistance to **access** their auto-injector or nasal spray? ☐ Yes ☐ No

If yes, auto-injector or nasal spray is kept:

Location: _____ With: _____

Other: _____

If no, student will carry their auto-injector or nasal spray at all times: in the classroom, outside the classroom (e.g., library, cafeteria/lunchroom, gym) and off-site (e.g., field trips/ excursions).

Auto-injector or nasal spray in student's:
☐ Backpack/fanny pack
☐ Other (specify) _____

Additional auto-injector or nasal spray:
The student has an additional auto-injector or nasal spray at the school? ☐ Yes ☐ No

If yes, the additional auto-injector or nasal spray is kept:

Location: _____ With: _____

Other: _____

EMERGENCY PROCEDURES (DEALING WITH AN ANAPHYLACTIC REACTION)

ACT QUICKLY. THE FIRST SIGNS OF A REACTION CAN BE MILD, BUT SYMPTOMS CAN GET WORSE QUICKLY.

STEPS

1. Give epinephrine auto-injector (e.g. EpiPen®) or nasal spray (e.g. neffy®) at the first sign of a known or suspected anaphylactic reaction.
2. Call 9-1-1. 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. Follow direction of emergency personnel, including transport to hospital (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).

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.

☐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

1. _____ 2. _____ 3._____

4._____ 5._____ 6._____

Other individuals to be contacted regarding Plan Of Care:

Before-School Program ☐Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver/Route # (If Applicable) _____

Other: _____

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): _____ Date: _____
Signature

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

Consent Form (Self-Administer and/or Employee Administer)

To Carry and Administer Medication for a Prevalent Medical Condition

CONSENT FORM

TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the _____ (school board) as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT

Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____ to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT

Student's Name: _____ Class/Teacher: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Name of Physician: _____ Physician Phone #: _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Personal information on this form is collected under the authority of the *Education Act* and s. 28(2) of the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA). It will be used to develop and administer the student's emergency Plan of Care and may be shared with authorized YCDSB staff and emergency responders as necessary. Questions about this collection should be directed to the Principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the _____ (School Board) through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

❒ classroom ❒ staffroom ❒ lunchroom ❒ other

❒ office ❒ school bus ❒ gym

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (□) all applicable boxes

❒ Food service providers ❒ Child care providers

❒ Board approved transportation carriers □ Other _____

❒ School volunteers in regular direct contact with my child

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(if 18 years of age or older)

Signature of Principal: _____ Date: _____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR.