

### Emergency Action Plan Form

**For Use In:** Classroom, Lunchroom, Staff Room, Office and/or Fanny Pack

A new form must be submitted each school year, while attending summer programs and whenever the medication is modified.

**PLEASE PRINT**

School Year: \_\_\_\_\_

**Health Alert For:** \_\_\_\_\_

Wears a Medic Alert tag? YES \_\_\_ NO \_\_\_

#### **ALLERGY DESCRIPTION**

This student has a **DANGEROUS, LIFE-THREATENING** allergy to the following foods (bee sting, drug, etc.):

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And all foods (insects, drugs, etc.) containing them in any form, and in any amount including the following kinds of items:

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## AVOIDANCE

The key to preventing an emergency is **ABSOLUTE AVOIDANCE** of allergens. Please list eating rules, if any, in the following space:

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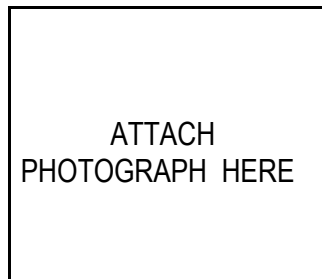
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## POSSIBLE SIGNS

- \* overwhelming, intense sense of impending doom
- \* itchiness of eyes, lips and/or tongue
- \* hives, swelling, blotchy redness
  
- \* tightness in throat, shortness of breath, wheezing, marked nasal stuffiness, trouble swallowing
- \* weakness, dizziness, paleness, sweatiness
- \* nausea, vomiting, cramps
- \* rapid, weak pulse rate
- \* sudden unsteadiness, loss of consciousness, breathing stops  
( From The Lung Association)



## REGULAR MEDICATION

Name(s)	How much/often	Possible side effects
_____	_____	_____
_____	_____	_____
Emergency _____		Expiry Date: _____
Medication: _____		Expiry Date: _____
_____		Expiry Date: _____

## CONTACTS

Name of Parent/Guardian: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

Other contact person(s): \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Hospital Phone #: \_\_\_\_\_ Ambulance Phone #: \_\_\_\_\_

**Emergency Medication Location:** \_\_\_\_\_

I/We hereby request that the above medication be administered to my/our child by the Algonquin and Lakeshore Catholic District School Board, its employees or agents. I/We acknowledge that the employees or agents of the Algonquin and Lakeshore Catholic District School Board are not medically trained to administer medications. Please note that this request will terminate at the end of the school year or when the prescription changes or expires.

\_\_\_\_\_  
Parent(s) / Guardian(s) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Principal=s Signature

\_\_\_\_\_  
Date

ANAPHYLAXIS: For the same allergen exposure, symptoms will probably be the same in timing, severity, treatment and outcome

SIGNS:

- \* overwhelming, intense sense of impending doom
- \* itchiness of eyes, lips and/or tongue
- \* hives, swelling, blotchy redness
- \* tightness in throat, shortness of breath, wheezing, marked nasal stuffiness, trouble swallowing
- \* weakness, dizziness, paleness, sweatiness
- \* nausea, vomiting, cramps
- \* rapid, weak pulse rate
- \* sudden unsteadiness, loss of consciousness, breathing stops.

WHAT TO DO:

- \* If a food or drink is suspect, rinse out the mouth
- \* If there is sudden, severe breathing difficulty or sudden unsteadiness, administer epinephrine (Epi-Pen, Anna Kit) in the thigh immediately (hold in place for 10 seconds) and repeat every 15 minutes if symptoms persist until at the hospital
- \* If in doubt or if two or more signs develop, give the epinephrine (Epi-Pen, Ana-Kit)
- \* If inhaled reliever medication is available, give it
- \* Administer any other prescribed allergy medication eg. Benadryl, after giving epinephrine
- \* Go immediately to the emergency department of the closest hospital, even if symptoms have completely resolved.

(From The Lung Association)