

## EXTREME ALLERGY MANAGEMENT and EMERGENCY PLAN

SCHOOL YEAR 2\_\_\_\_-2\_\_\_\_

## PART I – STUDENT INFORMATION

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Year / Month / Day

Medicare Number: \_\_\_\_\_

School: \_\_\_\_\_ Home room teacher: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)

Other contact: \_\_\_\_\_  
(i.e. caregiver)

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell)

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

What type of EpiPen® (epinephrine) does this child require?  Regular (33 lbs. or more)  
 Junior (less than 33 lbs.)

## Allergy Information (to be completed by student's physician)

**Anaphylaxis (Anaphylactic shock)** is a severe allergic reaction that can involve several body systems and lead to death if left untreated. Anaphylaxis can result from reactions to foods, insect stings, medications, latex and other substances. The most common food triggers of anaphylaxis are peanut, tree nuts, shellfish, fish, milk, egg, wheat, soy and sesame. However, a wide variety of other foods and exercise have been known to trigger anaphylaxis. Trace amounts of an allergen can trigger a severe reaction.

Child at risk of anaphylactic reaction?  Yes  No

If yes, to what? \_\_\_\_\_

Any other significant allergies?  Yes  No

If yes, describe \_\_\_\_\_

EpiPen® (epinephrine) recommended?  Yes  NoPhysician \_\_\_\_\_  
signatureDate: \_\_\_\_\_  
year / month / day

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**PART II – EXTREME ALLERGY MANAGEMENT PLAN**

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This part is to be completed by the school in collaboration with the parent.

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Parent's responsibilities: \_\_\_\_\_

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**PART II**

School's responsibilities: \_\_\_\_\_

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Student's responsibilities: \_\_\_\_\_

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**Appendix D  
EXTREME ALLERGY MANAGEMENT  
and EMERGENCY PLAN**

**Student:** \_\_\_\_\_

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**PART III – EMERGENCY PLAN**

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This part is to be completed by the school in collaboration with the parent. (eg. administer EpiPen®; call an ambulance or drive to hospital; contact parents).

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**Parent's responsibilities:** \_\_\_\_\_

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**PART III**

- I agree to have relevant information about my child's health/medical condition posted in strategic areas of the school (e.g. classroom, cafeteria, library, staff room) to assist staff in providing emergency services to my child. I will provide a photo of my child for this purpose.
- I do not wish information about my child to be posted in the school.

**School's responsibilities:** \_\_\_\_\_

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**Appendix D  
EXTREME ALLERGY MANAGEMENT  
and EMERGENCY PLAN**

**Student:** \_\_\_\_\_

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**PART IV – SIGN-OFF**

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I have read and understand the *Extreme Allergy Management and Emergency Plan* and agree to the sharing of information relevant to the service requested with those persons who must know in order to provide the service.

**Student (16 years and older):** \_\_\_\_\_ signature      **Date:** \_\_\_\_\_ year / month / day

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I hereby request and authorize school personnel to provide the care described above to my child. I understand school personnel have no medical qualifications and will perform the requested service in good faith and within the scope of the training received in accordance with this agreement.

In the event of an emergency, I authorize school personnel to administer the medication specified in this agreement and to obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and transportation.

I understand the school cannot guarantee an environment that is 100% allergen free.

I hereby acknowledge my responsibilities, as set out in this agreement and in Policy 704 - *Health Support Services*, and agree to carry these out to the best of my ability.

I agree to notify the school in writing of any changes to the information provided on this form.

I agree that the information provided on this form will be shared on a need-to-know basis with anyone who will be involved in the care of my child on behalf of the school.

I agree that the principal may contact my child's physician if he/she has questions:     Yes     No

**Parent/Guardian:** \_\_\_\_\_ signature      **Date:** \_\_\_\_\_ year / month / day

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I hereby acknowledge and accept my responsibilities and those of my staff, as set out in this agreement.

**Principal:** \_\_\_\_\_ signature      **Date:** \_\_\_\_\_ year / month / day

**PART IV**

**Appendix D  
EXTREME ALLERGY MANAGEMENT  
and EMERGENCY PLAN**

**Student:** \_\_\_\_\_

**ANNUAL REVIEW**

**Note:** if the requirements of the service requested have changed, complete a new *Extreme Allergy Management and Emergency Plan* form. If no changes, use this sign-off sheet to confirm plan has been reviewed with the parent.

This plan remains in effect for the 2\_\_\_\_\_-2\_\_\_\_ school year without change.

**Parent/Guardian:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

**Principal:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

This plan remains in effect for the 2\_\_\_\_\_-2\_\_\_\_ school year without change.

**Parent/Guardian:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

**Principal:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

This plan remains in effect for the 2\_\_\_\_\_-2\_\_\_\_ school year without change.

**Parent/Guardian:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

**Principal:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

This plan remains in effect for the 2\_\_\_\_\_-2\_\_\_\_ school year without change.

**Parent/Guardian:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

**Principal:** \_\_\_\_\_  
signature

**Date:** \_\_\_\_\_  
year / month / day

CHILD'S NAME \_\_\_\_\_

Teacher \_\_\_\_\_

Date of Birth: \_\_\_\_\_

EpiPen Syringe Expires: \_\_\_\_\_

Dr.: \_\_\_\_\_

Medicare # \_\_\_\_\_

Medic Alert Bracelet - Yes / No      Emergency Tele: Mother: \_\_\_\_\_ )

: \_\_\_\_\_ ) + 911

Father : \_\_\_\_\_ )

**SEVERE HEALTH PROBLEMS / ALLERGIES:**

<u>Possible Causes</u>	<u>Signs &amp; Symptoms</u>	<u>Action</u>

**OTHER ALLERGIES / HEALTH PROBLEMS**

<u>Possible Causes</u>	<u>Signs &amp; Symptoms</u>	<u>Action</u>

Location of "Medication": \_\_\_\_\_  
(EpiPen / other medication)

**Policy 704 (Policy for Providing Health Support Services in Public Schools) states the following:**  
***It is the responsibility of the parent/guardian to "Ensure that a student with conditions like severe allergies, asthma, diabetes or any other life-threatening conditions carries, every day, an EpiPen® or any other prescribed essential medication on his/her person (usually kept around the student's waist in a carrying pouch). School personnel should not be expected to search for proper medication in responding to an emergency situation".***

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_