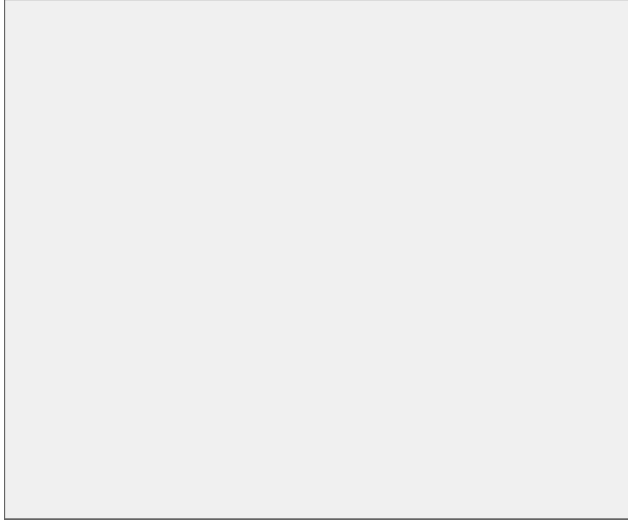


Food Allergy (risk for anaphylaxis) Care Plan

USE THIS PLAN IN ADDITION TO THE ANAPHYLAXIS EMERGENCY PLAN, WHEN NEEDED

Identification	Child's Name Click here to enter text.	Date of Birth: Click here to enter text.	Health Card Number: Click here to enter text.	MedicAlert® Number: Click here to enter text.
	Does your child carry an Emergency Health Services (EHS) Special Patient Protocol card with them? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Allergies: Click here to enter text.	Medical Diagnosis(es): Click here to enter text.	 Place Photo Here	
	Is your child aware of their diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Does your child experience fears and/or anxiety related to their health care needs/medical diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	If yes, please describe helpful coaching/support/management strategies: Click here to enter text.			
	Medications required during school hours: N/A <input type="checkbox"/> 1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text.		Location where medication is stored at the school (refer to Board policy) 1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text.	
Bus Driver(s) and Bus numbers(s) (if applicable):				
Morning Bus: Click here to enter text.		Afternoon Bus: Click here to enter text.		

Identification

This plan has been shared with bus operators, and /or other school designated person(s) providing transportation

Yes ☐ N/A ☐

Does your child have any activity restrictions while at school?

Yes ☐ No ☐

If yes, please describe:

[Click here to enter text.](#)

Emergency Contacts: Please prioritize 1,2,3, in the order the calls are to be placed:

Name	Relationship	Home Phone Number	Work Phone Number	Cell Phone Number	E-Mail
1. <input type="text"/>	1. <input type="text"/>	1. <input type="text"/>	1. <input type="text"/>	1. <input type="text"/>	1. <input type="text"/>
2. <input type="text"/>	2. <input type="text"/>	2. <input type="text"/>	2. <input type="text"/>	2. <input type="text"/>	2. <input type="text"/>
3. <input type="text"/>	3. <input type="text"/>	3. <input type="text"/>	3. <input type="text"/>	3. <input type="text"/>	3. <input type="text"/>

Identify the preferred method of communication, for non-emergency situations

- ☐ Phone call
☐ Text
☐ Email
☐ Communication book/agenda
☐ Other; please specify: [Click here to enter text.](#)


Additional Information:

[Click here to enter text.](#)

Designated school staff with allergy training: *(to be completed by school staff)*

- | | |
|--|--|
| 1. Click here to enter text. | 4. Click here to enter text. |
| 2. Click here to enter text. | 5. Click here to enter text. |
| 3. Click here to enter text. | 6. Click here to enter text. |

Allergies	<p>Identify food(s) your child avoids:</p> <p><input type="checkbox"/> Peanuts</p> <p><input type="checkbox"/> Tree Nuts</p> <p><input type="checkbox"/> Fish</p> <p><input type="checkbox"/> Crustaceans</p> <p><input type="checkbox"/> Shellfish</p> <p><input type="checkbox"/> Milk</p> <p><input type="checkbox"/> Eggs</p> <p><input type="checkbox"/> Sesame</p> <p><input type="checkbox"/> Soy</p> <p><input type="checkbox"/> Mustard Seed</p> <p><input type="checkbox"/> Wheat</p> <p><input type="checkbox"/> Other; please specify: Click here to enter text.</p>
	<p>Anaphylaxis Emergency Plan attached and on file: Yes <input type="checkbox"/></p> <p>Note: This is a requirement; please refer to your School Board's policy</p>
Meal/Snack Plan	<p>My child can eat among his/her peers: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, or if special instructions are required, please specify a plan (should be done in collaboration with the school principal):</p> <p>Click here to enter text.</p>
Goals And Responsibilities	<p>1. The goal in school and the shared responsibility of staff, parents, and students alike, is to minimize exposure and to be allergy aware.</p> <p>2. Anaphylaxis teaching including emergency response using epinephrine auto-injectors must be done with all staff annually and as needed (follow local school board's policy). This includes substitute teachers.</p> <p>3. All procedures should remain in place, even when the food-allergic child is absent from school.</p> <p>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 wipes can also be as effective (e.g. Wet Ones Antibacterial Wipes TM and Tidy Tykes Wipes TM). Alcohol based sanitizer is not effective in removing protein residue from the skin.</p>

	<p>Perry, T. T., Conover-Walker, M. K., Pomés, A., Chapman, M. D., & Wood, R. A. (2004). Distribution of peanut allergen in the environment. <i>The Journal of Allergy and Clinical Immunology</i>, 113(5), 973-976.</p>	
Av oid an ce Str ate gie s	<p>Identify avoidance strategies that must be in place, as applicable</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> My child should place their meals on a napkin or designated placemat.</p> <p><input type="checkbox"/> My child 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.</p> <p><input type="checkbox"/> Specific cleaning of surfaces and floors within rooms where contaminating food is consumed and the child will be.</p> <p><input type="checkbox"/> Supervision during meal/snack times by someone who has anaphylaxis training and knows how to use an epinephrine auto-injector.</p> <p><input type="checkbox"/> Specific hand washing routines for my child (before and after eating, and as needed).</p> <p><input type="checkbox"/> Specific hand washing routines for staff and students (before entering the classroom, after eating, and as needed).</p> <p><input type="checkbox"/> No sharing or trading of food</p>	
Epi nep hri ne Aut o- Inje cto r	<p>Identify the brand of epinephrine auto-injector your child owns: <input type="checkbox"/> Allerject™ <input type="checkbox"/> EpiPen®</p> <p>My child's auto-injector is stored:</p> <p><input type="checkbox"/> On their person</p> <p><input type="checkbox"/> Other: please specify Click here to enter text.</p> <p><i>*please refer to your School Board's policy regarding the location of the epinephrine auto-injector.</i></p>	
Hiv es	<p>Does your child typically get hives on their skin? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, complete the section below:</p>	
	Symptoms	Actions: Steps in Order
	<p>Presence of hives on the skin</p> <p>Pinkish/reddish swollen lesions with pale centres</p> <p>Lesions may be itchy</p> 	<p><u>If inside the body symptoms</u> are occurring with the hives give EPINEPHRINE AUTO-INJECTOR and follow the anaphylaxis emergency plan.</p> <p>Inside the body symptoms include:</p> <ul style="list-style-type: none"> • swelling of the lips and tongue; • itchy mouth or tongue, itchy throat; • throat tightness, hoarse voice; • hacking cough, repeated cough, choking; • trouble swallowing, trouble speaking; • trouble breathing, shortness of breath, wheezing; • vomiting, nausea, stomach pain, diarrhea;

C o n s e n t & A u t h o r i z a t i o n s		<ul style="list-style-type: none"> feeling dizzy, unsteady gait, feeling drowsy, feeling a sense of doom, feeling faint, or fainting. <p>If <u>no</u> inside the body symptoms are reported by the student, or are observed call parent/guardian immediately and follow their direction, or (Please specify):</p> <p>Click here to enter text.</p>
	Parent/Guardian/Student (if appropriate) Authorization Re: Consent to Release Information of the Health and/or Emergency Care Plan	
	<p>I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health, and safety of my child. This may include but is not limited to:</p> <ol style="list-style-type: none"> Display of my child's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of his/her medical condition. Place a copy of this plan in appropriate locations in the school including storing an electronic copy in my child's confidential record. Communication with school bus operators, or other school designated person(s) providing transportation. Any other circumstances that may be necessary to protect the health and safety of my child. 	
	Date	Parent/Guardian Signature
	Date	Student (if appropriate)
	Parent/Guardian/Student (if appropriate) Authorization Re: Consent for Implementation of the Health and/or Emergency Care Plan	
	<p>I have provided the information above and agree with the identified health care needs, interventions and/or the emergency responses outlined in this plan. 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.</p>	
	Date	Parent/Guardian Signature
	Date	Student (if appropriate)
	<p><i>Note: It is the parent(s)/guardian(s)' responsibility to notify the principal if there is a need to change the Health and/or Emergency Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.</i></p>	
	Authorizations	
	Date	Regulated Health Care Professional Signature and Designation
		Print Name



CAPE BRETON-VICTORIA
Regional School Board



Tri-County Regional School Board
Nova Scotia, Canada
Students First



	<hr/>	<hr/>
	<i>Date</i>	<i>Principal</i>
	<hr/>	<hr/>
	Plan is effective on: (insert date) <hr/>	
	<i>NOTE: Plans need to be reviewed, updated, and signed annually.</i>	