PREVALENT MEDICAL CONDITION - ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name | Date Of Birth | Student Photo (optional)

Age

Teacher | Grade

EMERGENCY CONTACTS (LIST IN PRIORITY)

1. Name | Relationship | Phone | Cell

2. Name | Relationship | Phone | Cell

3. Name | Relationship | Phone | Cell

KNOWN LIFE-THREATENING TRIGGERS

CHECK ( ) THE APPROPRIATE BOXES

☐ Food(s): | ☐ Insect Stings:

☐ Other:

It is an expectation that the student carry the Auto-injector on their person at all times.

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, vomiting, diarrhea, pain or cramps.
- **Cardiovascular system** (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or light headedness, 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): eating even a small amount of a certain food can cause a severe allergic reaction.

Safety measures:	
Food(s) to be avoided:	

Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where sting3 lont6ls nhest or conregaste. Deastryt orremove.

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) at the first sign of known or suspected anaphylactic reaction.

2. Call 9-1-1 or local emergency medical services. 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. Go to the nearest hospital immediately (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

I/We hereby request that the Kawartha Pine Ridge District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The Kawartha Pine Ridge District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in Board policies and administrative regulations. Parent(s)/guardian(s) and students acknowledge that the employees of the Kawartha Pine Ridge District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

PREVALENT MEDICAL CONDITION – ASTHMA
Plan of Care

☐ Smoke (e.g. tobacco, fire, cannabis, second-hand smo

☐ Other (Specify)

STUDENT INFORMATION

☐ At Risk for Anaphylaxis (Specify Allergen)

Student Name

Date Of Birth

Age

Teacher

Grade

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

1. Name

DAILY ROUTINE ASTHMA MANAGEMENT

RELIEVER INHALER USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

A reliever inhaler is a fast-acting medication (usually blue in colour) that is used when someone is having asthma symptoms.
It is an expectation that the student carry the reliever inhaler on their person at all times.

The reliever inhaler should be used:

☐ When student is experiencing asthma symptoms (e.g. trouble breathing, coughing, wheezing)

☐ Other (explain): _____

Use reliever inhaler _____ in the dose of _____

Name of Medication | Number of Puffs

Spacer (valved holding chamber) provided? ☐ Yes ☐ No

Place a (9) check mark beside the type of reliever inhaler that the student uses:

☐ Airomir ☐ Ventolin ☐ Bricanyl ☐

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

(*Student may also be restless, irritable and/or quiet.)

TAKE ACTION:

STEP 1: Immediately use fast-acting reliever inhaler (usually a blue inhaler). Use a spacer if provided.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone.
If symptoms get worse or do not improve within 10 minutes, this is an **EMERGENCY!**
Follow steps below.

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath

(*Student may also be anxious, restless, and/or quiet.)

THIS IS AN EMERGENCY:

STEP 1: **IMMEDIATELY USE ANY FAST-ACTING RELIEVER INHALER (USUALLY A BLUE INHALER). USE A SPACER IF PROVIDED.**
Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

STEP 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction).
- Do not have the student breathe into a bag.
- Stay calm, reassure the student and stay by his/her side.
- Notify parent(s)/guardian(s) or emergency contact.

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.
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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

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):

Authorization for the collection of this information is in the Education Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act, as amended and as applicable. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

DAILY/ROUTINE TYPE 1 DIABETES MANAGEMENT

Student is able to manage their diabetes care independently and does not require any special care from the school ☐ **Yes** ☐ **No**

If Yes, go directly to page five (5) - Emergency Procedures

ROUTINE	ACTION
BLOOD GLUCOSE MONITORING ☐ **Student requires trained individual to check BG/ read meter.** ☐ **Student needs supervision to check BG/ read meter.** ☐ **Student can independently check BG / read meter.** ☐ **Student has continuous glucose monitor (CGM)** *** Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.**	**Target Blood Glucose Range** **Time(s) to check BG:** **Contact Parent(s)/Guardian(s) if BG is:** **Parent(s)/Guardian(s) Responsibilities:** **School Responsibilities:** **Student Responsibilities:**
NUTRITION BREAKS ☐ **Student requires supervision during meal times to ensure completion.** ☐ **Student can independently manage his/ her food intake.** *** Reasonable accommodation must be made to allow student to eat all of the provided meals and snacks on time. Students should not trade or share food/ snacks with other students.**	**Recommended time(s) for meal/snacks:** **Parent(s)/Guardian(s) Responsibilities:** **School Responsibilities:** **Student Responsibilities:** **Special instructions for meal days/special events:**

ROUTINE	ACTION (CONTINUED)
DIABETES MANAGEMENT KIT **Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. field trips, fire drills, lockdowns) and advise parents when supplies are low.**	**Kits will be available in different locations but will include:** ☐ **Blood Glucose meter, BG test strips, and lancets** ☐ **Insulin and insulin pen and supplies** ☐ **Source of fast-acting sugar (e.g. juice, candy, glucose tabs.)** ☐ **Carbohydrate containing snacks** ☐ **Other (please list)** **Location of Kit:**
SPECIAL NEEDS **A student with special considerations may require more assistance than outlined in this plan.**	**Comments:**

EMERGENCY PROCEDURES

HYPOGLYCEMIA - LOW BLOOD GLUCOSE
(4 mmol/L OR LESS)
DO NOT LEAVE STUDENT UNATTENDED

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

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.)

Authorization for the collection of this information is in the Education Act, the Municipal Freedom of Information and Protection of

PREVALENT MEDICAL CONDITION - EPILEPSY
Plan of Care

STUDENT INFORMATION

Student Name | Date Of Birth | Student Photo (optional)

Age

Teacher | Grade

EMERGENCY CONTACTS (LIST IN PRIORITY)

1. Name | Relationship | Phone | Cell

2. Name | Relationship | Phone

DAILY/ROUTINE EPILEPSY MANAGEMENT

DESCRIPTION OF SEIZURE (NON-CONVULSIVE)	ACTION: (e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)
DESCRIPTION OF SEIZURE (CONVULSIVE)	**ACTION:**

SEIZURE MANAGEMENT

Note: It is possible for a student to have more than one seizure type. Record information for each seizure type.

SEIZURE TYPE (e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms)		ACTIONS TO TAKE DURING SEIZURE
Type:		
Description:		

Frequency of seizure activity:

Typical seizure duration:

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s):

Does student need to leave classroom after a seizure? ☐ Yes ☐ No

If yes, describe process for returning student to classroom:

BASIC SEIZURE FIRST AID

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

- Protect student's head
- Keep airway open/watch breathing
- Turn student on side

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.

Call 9-1-1 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water.

* Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include:

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: _____

Student: _____ Date: _____

Principal: _____ Date: _____

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GENERAL HEALTH CONCERNS
Plan of Care

STUDENT INFORMATION

Student Name		Date Of Birth		Student Photo (optional)
Age				
Teacher		Grade		

DAILY/ROUTINE MANAGEMENT

SYMPTOM DESCRIPTION:	ACTION: (e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)
MEDICATION(S):	LOCATION/TREATMENT:

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s):

EMERGENCY PROCEDURES

Students who require emergency medical assistance as a result of their medical condition:

Call 9-1-1 when:

* Notify parent(s)/guardian(s) or emergency contact.

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:

Professional/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.
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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:

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KAWARTHA PINE RIDGE DISTRICT SCHOOL BOARD

ADMINISTRATION OF MEDICATION LOG
Confidential

Student Name		Date Of Birth	
Name of Parent/Guardian		Home Telephone	
Address		Business Telephone	
City		Postal Code	
School		Teacher/Placement	
Physician's Name		Physician's Telephone	

Date	Time	Medication	Dosage	Signature of Person Administering	Comments