



705 Centre Road
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Mr. P. Messina, Principal

Mrs. L. Paolini, School Secretary

Mrs. V. Paci, Vice-Principal

Mrs. T. Ferrie, Superintendent of Education Rev. F. Noronha, Pastor, Guardian Angels Mr. M. Valvasori, School Trustee

September, 2021

Re: Medical Alert Information for Allergy/Anaphylaxis

Dear Parent(s)/Guardian(s),

The Hamilton-Wentworth Catholic District School Board has revised the HWCDSB School Health Procedures: Allergy/Anaphylaxis Plan as of September 2018.

“As primary caregivers of their child, parents are expected to be active participants in supporting the management of their child’s medical condition(s) while the child is in school. Failure to complete the forms described below prior to October 1 of the new school year could result in the student being excluded from school”.

The following forms are being sent home to ensure the management plans at school are current and comply with these new procedures.

1. **Appendix A:** Annual Parent(s)/Guardian(s) Request and Consent for Allergy/Anaphylaxis Intervention (to be completed by parent(s)/guardian(s) annually)
2. **Appendix B:** Physician Authorization for Administration of Medication for Anaphylactic Reaction (for new students or if information has changed)
3. **Appendix C:** Individual Allergy/Anaphylaxis Plan of Care *New form as of September 2018*
4. Provide a minimum of two (2) up-to-date medications (ie. epinephrine auto-injectors). Arrange to have one (1) epinephrine auto-injector on the student’s person (ie. in a fanny pack) at all times (a backpack is not acceptable); and one (1) epi-pen to be stored in the office.

*To order a free fanny pack for your child please call 1-877-374-7361.

“Forgive, Understand, Love and Lead”

5. Appendix H: Allergy/Anaphylaxis Management Plan Waiver must be signed if you decide that your child:

- a) will bring only 1 epinephrine auto-injector to school;
- b) will not carry their epinephrine auto-injector on them during the school day;
- c) will not sit in a designated seat close to the bus driver while riding the bus;
- d) will have an alternative plan regarding their emergency allergy/anaphylaxis.

Please see next page

Please return the following completed package with signatures no later than Monday, September 20th, 2020. If you have any questions or concerns, please contact Mrs. Brown, Mrs. Paci or Mr. Messina at 905-523-2345. Thank you for your continued support.

Sincerely,

A handwritten signature in black ink, appearing to read "P. Messina", is written over a horizontal line. The signature is cursive and includes a long, sweeping flourish at the end.

Mr. P. Messina / Principal

“Forgive, Understand, Love and Lead”

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD
ANNUAL PARENT(S)/GUARDIAN(S) REQUEST AND CONSENT FOR ALLERGY/ ANAPHYLAXIS
INTERVENTION
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ANAPHYLACTIC REACTION

To Be Completed by Parent/Guardian/Adult Student Annually
(Please Print or Type)

Demographic Information

Student's Name: _____ Birthdate: Month ____ Day Year _____

Administration of Medication

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not trained medical personnel, however I authorize the administration of an epinephrine auto-injector, as prescribed by the attending physician, in the event that my child, _____ experiences an anaphylactic reaction on school property or during a school or school board sponsored event. I also understand that my child may need to be held in order to administer the epinephrine auto-injector and consent to same.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month ____ Day Year ____

Principal Signature: _____

Self-Administration of Medication

I consent to my child _____ carrying an epinephrine auto-injector on her/his person.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month ____ Day Year ____

Principal Signature: _____

Ana

I consent to my child _____ self-administering the epinephrine auto-injector prescribed by the attending physician, if physically capable.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month _____ Day Year __

Principal Signature: _____

Posting of Photographs and Individual Allergy/Anaphylaxis Plan of Care

I consent to the posting of photographs of my child _____ and of medical information related to my child (Individual Allergy/Anaphylaxis Action Plan) in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month _____ Day Year __

Principal's Signature: _____

Consent to the Development of an Individual Allergy/ Anaphylaxis Plan of Care

I consent to the development of an Individual Allergy/ Anaphylaxis Plan of Care for my child _____. This plan will outline the emergency steps that shall be taken if my child experiences an anaphylactic reaction on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: Month _____ Day Year __

Principal's Signature: _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in main office)

This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.

Hamilton-Wentworth Catholic District School Board
PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
FOR ANAPHYLACTIC REACTION

Complete When The School is First Informed of Condition or if the Condition Changes

To be Completed by Attending Physician/ Nurse Practitioner
(Please Print or Type)

Demographic Information

Student's Name: _____

Birthdate: _____ Month Day Year _____

Ontario Education Number (OEN): _____

Description of Allergy

Foods, products, substances etc. which are to be avoided:

Description of Symptoms of Allergic Reaction

- Cardiovascular System (Heart) _____
- Gastrointestinal System (Stomach) _____
- Respiratory System (Breathing) _____
- Skin System _____
- Other _____

Medical Certification

This is to certify that (Name) _____ has a potentially life-threatening allergy to _____ and must be given an epinephrine auto-injector in the event of an anaphylactic reaction.

Dosage:

- Epipen® Jr. 0.15 mg
- Epipen® 0.30 mg

Possible side-effects of medication administration: _____

Additional medications which may be administered after the epinephrine auto-injector include:

(Physician/Nurse Practitioner Authorization to be completed only when information is new or has changed)

Physician/ Nurse Practitioner Name: _____ Telephone: _____

Physician/ Nurse Practitioner Signature: _____

Date: Month _____ Day _____ Year _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in Main Office)

This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.



INDIVIDUAL ALLERGY/ ANAPHYLAXIS PLAN OF CARE

STUDENT INFORMATION		Coloured Student Photo
Student Name	Date of Birth	
Grade	Teacher(s)	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS	
CHECK (✓) THE APPROPRIATE BOXES	
<input type="checkbox"/> Food(s):	<input type="checkbox"/> Insect Stings:
<input type="checkbox"/> Other:	
Epinephrine Auto-Injector(s) Expiry Date (s):	
Expired Medication will be returned to the parent/guardian/adult student.	
Dosage: <input type="checkbox"/> EpiPen® Jr. 0.15 mg	<input type="checkbox"/> EpiPen® 0.30 mg
Medication Location #1 (on the student):	Medication Location #2:
<input type="checkbox"/> Previous anaphylactic reaction: Student is at greater risk.	
<input type="checkbox"/> Has asthma. Student is at greater risk. If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.	
<input type="checkbox"/> Any other medical conditions or allergies?	

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 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.

Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.

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:

**EMERGENCY PROCEDURES
(DEALING WITH AN ANAPHYLACTIC REACTION)**

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).
- 6.
- 7.
- 8.
- 9.
- 10.

Refer to Appendix P for the Board Policy on Allergic Reactions (Anaphylaxis Awareness)

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 on the Physician/nurse practitioner Authorization Form.

*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

		Yes (Please Initial for each)	No (Please Initial for each)
We the Parents/Guardians consent to the carrying of an epinephrine auto-injector on her/his person.			
We the Parents/Guardians consent to the self-administration of medication.			
We the Parents/Guardians consent to the administration of medication.			
We, the Parents/Guardians request the posting of this Individual Plan of Care, including recent colour photo in the:	School Staff Room		
	Elementary Homeroom Classroom		
	School Main Office		
We the Parents/Guardians request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, volunteers, and school bus drivers.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care with students in the classroom.			
We the Parents/Guardians request the sharing of information on signs and symptoms of anaphylaxis specific to the needs outlined in this Plan of Care through a letter home to families of students in the classroom.			
We, the Parents/Guardians request the sharing of this Individual Plan of Care with the Before and After-School Program.			

TRANSPORTATION

School Bus Driver/Route # (If Applicable) New Plan of Care Updated Plan of Care

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) Signature :	Date:
Adult Student Signature:	Date:
Principal Signature:	Date:



Mr. P. Messina, Principal

Mrs. O Tsiodras, School Secretary

Mrs. J. Townsend, Vice-Principal

Mr. M. Hucal, Superintendent of Education

Mr. M. Valvasori, School Trustee

Appendix H

August 2020.

Re: Medical Alert Information for Allergy/Anaphylaxis

Dear Parents/Guardians:

As you are aware, the Allergy/Anaphylaxis Management Plan of the Hamilton-Wentworth Catholic District School Board requires that:

- the parents/guardians of a student, who is at risk to have an anaphylactic reaction provide the school Principal/Designate with two (2) epinephrine auto-injectors for the use of their child while s/he is attending school;
- the child, who is at risk to have a anaphylactic reaction has one (1) epinephrine auto-injector on her/his person while at school, on the school bus or while participating in school sponsored activities away from the main school campus;
- the child, who is at risk to have an anaphylactic reaction sits in a designated seat close to the bus driver while riding the school bus;
- _____

It is my understanding that:

- you wish to provide the school Principal/Designate with only one (1) epinephrine auto-injector for your child's use;
- you do not agree to have your child carry one (1) epinephrine auto-injector on her/his person;
- you do not wish to have your child sit in a designated seat on the school bus close to the bus driver;
- _____

I would ask you, therefore, to complete the form attached to this letter waiving one or more of the above requirements and return it to me in the enclosed envelope as soon as possible.

P. Messina
Principal

**Allergy/Anaphylaxis Management Plan
Waiver (cont.)**

STUDENT: _____

SCHOOL: _____

	Father's Signature:	Mother's Signature:	Guardian's Signature:
<input type="checkbox"/> I/We have decided that one (1) epinephrine auto-injector will be provided for my/our child _____ while s/he is attendance at the school.			
	(Date)	(Date)	(Date)
<input type="checkbox"/> I/We have decided that my/our child _____, will <u>not</u> carry an epinephrine auto-injector on her/his person while s/he is in attendance at school.			
	(Date)	(Date)	(Date)
<input type="checkbox"/> I/We have decided that my/our child _____ will <u>not</u> sit in a designated seat close to the bus driver while riding the school bus.			
	(Date)	(Date)	(Date)
<input type="checkbox"/> I/We have decided that my/our child _____ _____ _____			
	(Date)	(Date)	(Date)

Routing: Original - Principal. Copy - Parent/Guardian. Copy - Superintendent of Education