2022-2023 MSK Anaphylaxis Emergency Plan:

***NAME:* ___________________________________ *CLASSROOM:* ___________________________**

This person has a potentially life-threatening allergy (anaphylaxis) to:

(Check the appropriate boxes)

☐ FOOD(S):____

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☐ Medication (please list):____________________________________

☐ Insect Stings (please specify insect)__________________________

☐ Latex

☐ Other (please list):____

Epinephrine Auto-Injector ("Epipen"): Expiry Date _____________________/____________________

Dosage: ☐ **EpiPen Jr 0.15 mg** ☐ **EpiPen 0.3 mg** ☐ **Allerject 0.15 mg** ☐ **Allerject 0.3 mg**

☐ **Emerade 0.3 mg** ☐ **Emerade 0.5 mg**

Location of Auto-Injector(s): **____**

☐ **Previous anaphylactic reaction:** Person is at greater risk.

☐ **Asthmatic:** Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector **<u>before</u>** asthma medication.

A person having an anaphylactic reaction might have ANY of these signs & 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, pain or cramps, vomiting, diarrhea
- **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 & immediate treatment could save a person's life.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly:

1) **Give epinephrine auto-injector** (e.g. EpiPen or Allerject, Emerade) at the first sign of a known or suspected anaphylactic reaction. (See attached instruction sheet.)
2) **Call 911** 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 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 proper 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, guardian).**

Emergency Contact Information

Name	*Relationship*	*Home Phone*	*Work Phone*	*Cell Phone*

The undersigned patient, parent or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

____   ___________________________

Parent/Guardian Signature   Date

Anaphylaxis Emergency Plan

Child's Name: ____ **Date of Birth**: _________________________

Child's Address: ____________________________________ **Home Telephone**: _______________________________

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Emergency Action Plan on the onset of reaction: (To be filled in by parent and to be followed as indicated below)

Child Care Staff Roles and Responsibilities:

- Adhere to _________________________ Anaphylactic Policy
- Staff will conduct a check to confirm child (ren) have their required medication with them before each transition, (ie. moving from the classroom to the gym, leaving for school, etc.)
- Administer medications and/or instructions as set out in child's Individual Plan and Emergency Procedures
- Staff is to remain calm
- Staff will be debriefed
- Written report to be filled out by staff dealing with emergency
- Serious Occurrence to be filed

Parent Agreement

I ______________________________ acknowledge my participation in the development of the preceding Emergency Action Plan and agree to execute reliability the parent commitments listed within them.
I give my consent for the staff of **Montessori School in Kleinburg Inc.** to execute the child care commitment as outlined within the plan.
In the event of an emergency, I authorize the staff of **Montessori School in Kleinburg Inc.** to administer the designated medication and obtain medical assistance. I agree to assume responsibility for all costs associated with medical treatment and absolve **Montessori School in Kleinburg Inc.** and its employees/volunteers of responsibility for any adverse reaction resulting from administration of the medication.

Parent Signature: ____ Date: __________________________