Durham Catholic District School Board

Protection of Anaphylactic Students

Individual Student Plan

Name of Student
School and Grade
Date of Birth

Affix Student Photo Here

1. Personal Information

Student Name:	First:	Last:
D.O.B. (yyy/mm/dd)	O.E.N.	Gender: Male ☐ Female ☐
Home Address:	Street	City Postal Code

Parent(s)/Guardian(s) Information

1. Name:	2. Name:
Address: Street	Address: Street
City Postal Code	City Postal Code
Home Phone Number:	Home Phone Number:
Work Phone Number:	Work Phone Number:
Cell Phone Number:	Cell Phone Number:

2. Emergency Contacts

1. Name:	2. Name:
Address: Street	Address: Street
City Postal Code	City Postal Code
Home Phone Number:	Home Phone Number:
Work Phone Number:	Work Phone Number:
Cell Phone Number:	Cell Phone Number:

3. Physician's Instructions

The Durham Catholic District School Board Policy for the Protection of Anaphylactic Students provides a framework for creating safe classroom environments through preventative strategies and appropriate emergency response. It is not within the mandate of the Board's policies to create allergy-free schools.

This form is requested under the authority of the Education Act and the policy of the Durham Catholic District School Board for Protection of Anaphylactic Students.

Name of Student	Parent(s) Guardian(s) Name:	
Address: Street	City	Postal Code

1. Does this patient have a known pre-disposition to anaphylaxis?

2. What is the nature of the anaphylactic reaction?

3. What medication is to be administered in the event of an anaphylactic reaction?

Please indicate: Name of Medication:	Dose or amount to be given:	Total Doses or times per event:

Additional Instructions:

Prescribing Physician's Name:

Address: Street	City	Postal Code	Phone Number:
Attending Physician's Signature:		Date:	

4. Pre-authorization for the Administration of Medication

I hereby pre-authorize and give permission for, ______________________________

Name of School

to administer medication to my child in the event of an anaphylactic reaction, according to the Board's policies and procedures and the physician's prescription and instructions as described within this individual student plan.

Parent(s)/Guardian(s) Signature Date

Student's Signature Date

Durham Catholic District School Board

Consent to the Release of Medical Information

I, ____
(Print full name: First Name, Last Name of Parent/Guardian or Adult Student)

of ____
(Address)

hereby consent to the release of medical information compiled/prepared by: ______________________
(Name of Attending Physician)

____
(Address)

in respect to: ____
(Name of Student) *(Date of Birth)*

to: ____
(Name of School)

____
(Address)

for the purpose of developing the Individual Student Plan and for the Protection of Anaphylactic Students.

Special Instructions: ____

____

____
Signature of Parent/Guardian or Adult Student

______________________________ ______________________________
Witness: Printed Name Witness Signature

Dated this ______________________day of ______________________, ______________.

This consent to release information remains valid until * ______________________ (maximum one year from date of signature)

* *Authorizing person may cancel or change this authorization in writing at any time prior to the expiry date, unless action has already been taken on the basis of the authorization.*

Durham Catholic District School Board

Consent to the Release of Personal Information

I, ____
(Print full name: First Name, Last Name of Parent/Guardian or Adult Student)

of ____
(Address)

hereby consent to the release of personal information in respect to:

____

(Name of Student) *(Date of Birth)*

to the staff of ____
(Name of School)

____
(Address)

for the purpose of establishing prevention strategies and an emergency response in the event of an anaphylactic reaction.

____
Signature of Parent/Guardian or Adult Student

____
Witness: Printed Name Witness Signature

Dated this ______________________day of __________________________, _________________.

This consent to release information remains valid until * _______________________
(maximum one year from date of signature)

* *Authorizing person may cancel or change this authorization in writing at any time prior to the expiry date, unless action has already been taken on the basis of the authorization.*

Student Name: ______________________________

Nature of the Anaphylaxis

- Allergic to: ______________________________

- Indications of a severe allergic reaction: ______________________________

PREVENTION	Strategies to Prevent an Anaphylactic Reaction	EMERGENCY RESPONSE	Response and Treatment

Contingencies for Field Trips and Excursions

Durham Catholic District School Board

Anaphylactic Student’s
Log of Interventions and/or
Administration of Medication

Name of Student:	Date of Birth: (yyyyy/mm/dd)
School:	Grade:

Date (yyyy/mm/dd)	Time	Type of Intervention	Medication Administered (Name and Dose)	Attending Staff (Print Name)	Attending Staff Signature	Comments