Authorization for Administration of Epinephrine & Anaphylaxis Standard Health Care Plan (SHCP)

(To be completed by parent)

School name: ______________________________ **School year:** ______________

Student information

Name: ______________________________ Birthdate: ______/______/______
Year Month Day

Address: ______________________________

MHSC # (6 digit):____________ PHIN # (9 digit): ______________

Parent information

Parent: ______________________________ Daytime phone(s) ______________

Parent: ______________________________ Daytime phone(s) ______________

Emergency contact: ______________________ Daytime phone(s)____ ______________

Medical information

Name & Dose			
	☐ EpiPen® Jr 0.15 mg (green)	☐ Allerject® 0.15 mg (blue)	☐ Emerade™ 0.3 mg
	☐ EpiPen® 0.3 mg (yellow)	☐ Allerject® 0.3 mg (orange)	☐ Emerade™ 0.5 mg

Name of prescribing physician: ______________________

Life-threatening allergy(s): ______________________________

☐ Back-up epinephrine auto-injector provided to school Location: ______________

The parent has the option of supplying an extra epinephrine auto-injector to be kept in a secure location but unlocked for quick access.

Parent authorization

As per school division policy, the student shall carry their epinephrine auto-injector on their person.

☐ I, the parent, will ensure the child named above carries their epinephrine auto-injector on their person while attending school.

I understand that:

- Authorization to administer epinephrine is renewed annually with student registration or upon a change in medication.
- The pharmacy label must be on the epinephrine auto-injector.
- The parent is responsible for replacing expired medication as well as the removal and disposal of expired medication.

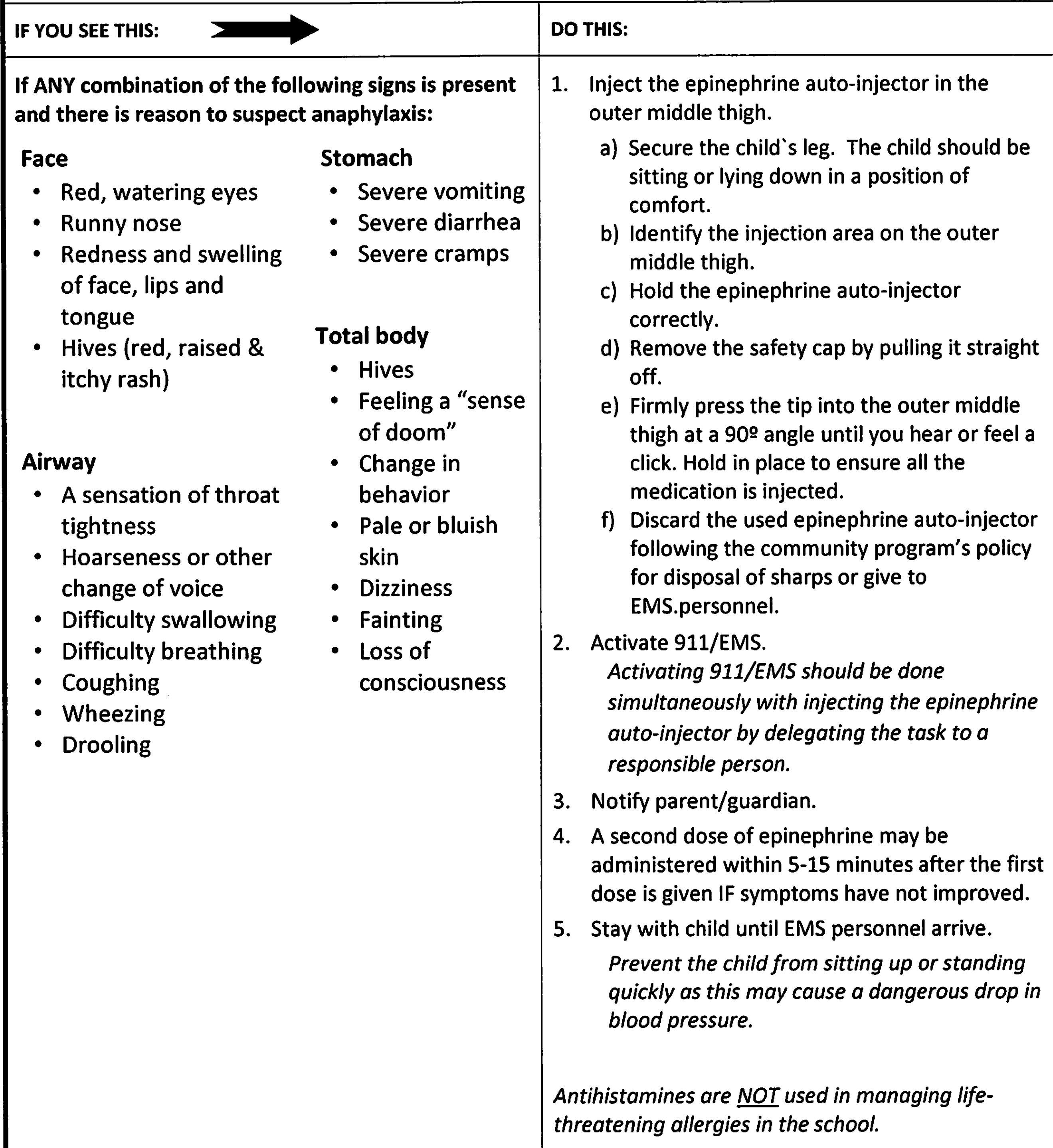
I hereby request and authorize the school to administer the medication named above to my child as outlined in the attached Anaphylaxis Standard Health Care Plan.

Parent signature: ______________________________ **Date:** ______________

School administrator signature: ______________________________ **Date:** ______________

Anaphylaxis Standard Health Care Plan (SHCP)

The Anaphylaxis SHCP is based on the clinical practice guidelines developed by the Unified Referral and Intake System (URIS) in consultation with Children's Allergy and Asthma Education Centre (CAAEC) at Health Sciences Centre. These clinical practice guidelines are available on the URIS website. Unified Referral and Intake System (URIS) | Manitoba Education and Early Childhood Learning (gov.mb.ca)



IF YOU SEE THIS: →

If ANY combination of the following signs is present and there is reason to suspect anaphylaxis:

Face
- Red, watering eyes
- Runny nose
- Redness and swelling of face, lips and tongue
- Hives (red, raised & itchy rash)

Airway
- A sensation of throat tightness
- Hoarseness or other change of voice
- Difficulty swallowing
- Difficulty breathing
- Coughing
- Wheezing
- Drooling

Stomach
- Severe vomiting
- Severe diarrhea
- Severe cramps

Total body
- Hives
- Feeling a "sense of doom"
- Change in behavior
- Pale or bluish skin
- Dizziness
- Fainting
- Loss of consciousness

DO THIS:

1. Inject the epinephrine auto-injector in the outer middle thigh.
   a) Secure the child`s leg. The child should be sitting or lying down in a position of comfort.
   b) Identify the injection area on the outer middle thigh.
   c) Hold the epinephrine auto-injector correctly.
   d) Remove the safety cap by pulling it straight off.
   e) Firmly press the tip into the outer middle thigh at a 90º angle until you hear or feel a click. Hold in place to ensure all the medication is injected.
   f) Discard the used epinephrine auto-injector following the community program's policy for disposal of sharps or give to EMS.personnel.
2. Activate 911/EMS.
   Activating 911/EMS should be done simultaneously with injecting the epinephrine auto-injector by delegating the task to a responsible person.
3. Notify parent/guardian.
4. A second dose of epinephrine may be administered within 5-15 minutes after the first dose is given IF symptoms have not improved.
5. Stay with child until EMS personnel arrive.
   Prevent the child from sitting up or standing quickly as this may cause a dangerous drop in blood pressure.

Antihistamines are NOT used in managing life-threatening allergies in the school.

Unified Referral and Intake System (URIS) Group B Application

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. If you have questions about the information requested on this form, you may contact the community program.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	
☐ School	Name of community program: Harold Hatcher School
☐ Licensed child care	Contact person: Vernon Eby & Kelsey Clark
☐ Respite	Phone: 204-958-6880 Fax: 204-224-4702
☐ Recreation program	Email: hh@retsd.mb.ca
	Address (**location where service is to be delivered**):
	Street: 500 Redonda Street
	City/Town: Winnipeg POSTAL CODE: R2C 3T7

Section II - Child information

Last Name **First Name**

Birthdate

month (print) D D Y Y Y Y

Also Known As

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.

☐ **Life-threatening allergy (and child is prescribed an EpiPen)**

Does the child bring an EpiPen to the community program? ☐ YES ☐ NO

☐ **Asthma (administration of medication by inhalation)**

Does the child bring asthma medication (puffer) to the community program? ☐ YES ☐ NO

Can the child take the asthma medication (puffer) on his/her own? ☐ YES ☐ NO

☐ **Seizure disorder**

What type of seizure(s) does the child have? __________________

Does the child require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

☐ **Diabetes**

What type of diabetes does the child have? ☐ Type 1 ☐ Type 2

Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO

Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO

Does the child have low blood sugar emergencies that require a response? ☐ YES ☐ NO

☐ **Cardiac condition** where the child requires a specialized emergency response at the community program.

What type of cardiac condition has the child been diagnosed with? __________________

☐ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? __________________

☐ **Steroid Dependence** (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease) What type of steroid dependence has the child been diagnosed with? ____________________
☐ **Osteogenesis Imperfecta (brittle bone disease)**
☐ **Gastrostomy Feeding Care** Does the child require gastrostomy tube feeding at the community program? ☐ YES ☐ NO Does the child require administration of medication via the gastrostomy tube at the community program? ☐ YES ☐ NO
☐ **Ostomy Care** Does the child require the ostomy pouch to be emptied at the community program? ☐ YES ☐ NO Does the child require the established appliance to be changed at the community program? ☐ YES ☐ NO Does the child require assistance with ostomy care at the community program? ☐ YES ☐ NO
☐ **Clean Intermittent Catheterization (IMC)** Does the child require assistance with IMC at the community program? ☐ YES ☐ NO
☐ **Pre-set Oxygen** Does the child require pre-set oxygen at the community program? ☐ YES ☐ NO Does the child bring oxygen equipment to the community program? ☐ YES ☐ NO
☐ **Suctioning (oral and/or nasal)** Does the child require oral and/or nasal suctioning at the community program? ☐ YES ☐ NO Does the child bring suctioning equipment to the community program? ☐ YES ☐ NO

Section III - Authorization for the Release of Medical Information

I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's physician(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for ______________________________.
(child's name)

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

______________________________ ____________________
Parent/Legal guardian signature Date

______________________________ ______________ ____________________
Mailing Address Postal Code Phone number