HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

ANNUAL PARENT/GUARDIAN REQUEST AND CONSENT FOR ALLERGY/ ANAPHYLAXIS INTERVENTION

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ANAPHYLACTIC REACTION

To Be Completed by Parent/Guardian 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/nurse practitioner, 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 this procedure**.

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: _____

I consent to my child _____ self-administering the epinephrine auto-injector prescribed by the attending physician/nurse practitioner, 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: _____