TURTLE MOUNTAIN SCHOOL DIVISION	4 – G

REGISTRATION FORM

PLEASE NOTE: TURTLE MOUNTAIN SCHOOL DIVISION IS WORKING TOWARD BEING FISH AND NUT FREE.

This form must be completed and signed by the parent/legal guardian of any student(s) new to Turtle Mountain School Division as required by the Freedom of Information and Protection of Privacy Act.

☐ Boissevain School
☐ Can Am Colony School
☐ Holmfield Colony School
☐ Killarney School
☐ Mayfair Colony School
☐ Minto School
☐ Wellwood Colony School

☐ Child in Care Agency:_____
Agency Worker:_____
Phone:_____ Fax:_____

*The school registration Child in Care Form must be completed with Executive Director signature before school Entry

APPLICATION DATE _____ PREVIOUS SCHOOL _____ APPLYING FOR GRADE _____

STUDENT LEGAL NAME (LAST) _____ (FIRST) _____ (MIDDLE) _____

Home Phone: _____ Unlisted: ☐ Date of Birth: _____ ____ ____ Sex: ____
year mo. Day

Email Address: _____

Student lives with: ☐ Mother ☐ Father ☐ Both ☐ Other (please specify) _____

Student Street Address: _____ Mailing Address: _____

Town: _____ Postal Code: ☐☐☐ ☐☐☐

Bus student: ☐ Yes ☐ No If Yes: ☐ Rural or ☐ **Town** Bus #: _____ Section/Township/Range _____
Note: If bus transportation is required, please fill in transportation form 6-D
School Division in which parent/legal guardian resides: _____

Male Parent: _____ Relationship (if not father): _____

Address & phone #: Same as student ☐ or: _____

Place of Employment: _____

Home Phone # _____ Work Phone # _____ Cell # _____

Female Parent: _____ Relationship (if not mother): _____

Address & phone #: Same as student ☐ or: _____

Place of Employment: _____

Home Phone # _____ Work Phone # _____ Cell # _____

Special custody circumstances: (if any)	Court documentation:

Legal Guardian's Name: _____ Relationship: _____

Address & phone #: Same as student ☐ or: _____

Place of Employment: _____

Home Phone # _____ Work Phone # _____ Cell # _____

Work email address: _____

Court Documentation for legal guardianship ☐ (copy to be placed in cum folder)

Brothers/Sisters Name:	D.O.B. (Year/Month/Day)	School/Grade Level:

Storm Billet: _____ (Bus Students Only)

Street Address and Phone #: _____

Medical Information: MHSC # ☐☐☐☐☐☐ (6 digit) PHIN # ☐☐☐☐☐☐☐☐☐ (9 digit)

Doctor: _____ Phone: _____

Emergency Contact **(if parent unavailable):** _____ Phone # _____

_____

Home Phone # _____ Work Phone # _____ Cell # _____

Babysitter/Daycare: _____ Address: _____ Phone # _____

In case of an emergency, I understand that the Turtle Mountain School Division will secure medical attention and contact emergency services(911/ambulance). I understand that I will be notified of an emergency as soon as possible.

_____ _____

PARENT/LEGAL GUARDIAN SIGNATURE DATE

HEALTH NEEDS:

1. Does your child have any health concerns? ☐ YES ☐ NO

2. Did a URIS Nurse develop a Health Care Plan last year? ☐ YES ☐ NO

If you answered YES to **one or both** of these questions, please complete URIS Referral & Intake form (attached).

If you answered NO to both questions, please sign and then continue to STUDENT SERVICES INVOLVEMENT on page 3.

PARENT NAME _____ DATE _____

STUDENT SERVICES INVOLVEMENT:

Please check any services listed that your child received previously.

_____ Psychologist
_____ Speech/Language Pathologist
_____ Guidance Counsellor
_____ Reading Recovery
_____ Individual Education Plan
_____ Health Care Plan
_____ Social Worker
_____ Occupational/Physical Therapy
_____ Consultant for Deaf/Hard of Hearing
_____ Consultant for Visually Impaired
_____ Mental Health

ENGISH AS AN ADDITIONAL LANGUAGE (EAL) LEARNER:

1. Is English an additional language? ☐ YES ☐ NO

If you answered YES, please complete the EAL Intake package (attached)

ADDITIONAL COMMENTS:

Aboriginal Identity Declaration
EIS Data Collection

Aboriginal Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Aboriginal learners.
(Providing this personal information is voluntary and optional. It is being collected in compliance with section 36(1)(b) of the Freedom of Information and Protection of Privacy Act it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs.)

1. I, _____, (name of parent/guardian, please print clearly):

   ☐ Am submitting my child's Aboriginal Identity Declaration for the first time.
   ☐ Am making changes to my child's Aboriginal Identity Declaration.
   ☐ Already submitted my child's Aboriginal Identity Declaration and have no further changes to make at this time.

2. Is your child an Aboriginal person, that is, First Nation (North American Indian), Metis, or Ink (Inuit)? Note: First Nations (North American Indian) include Status and Non-Status Indians
   If "Yes", mark the square(s) that best describe(s) your child now:

   ☐ Yes, First Nation (North American Indian)
   ☐ Yes, Metis
   ☐ Yes, Inuk (Inuit)

3. Which best describes your child's Aboriginal cultural-linguistic identity? Please select up to two choices:

   ☐ Anishinaabe (Objibway/Saulteaux)
   ☐ Dene (Sayisi)
   ☐ Oji-Cree
   ☐ Inuktitut
   ☐ Ininw
   ☐ Dakota
   ☐ Michif
   ☐ Other-please specify:_____

For more information on the Aboriginal Identity Field, please contact:
Manitoba Education, Citizenship and Youth
Aboriginal Education Directorate
Murdo Scribe Centre
510 Selkirk Avenue
Winnipeg, MB R2W 2M7
Telephone: (204) 945-7886
Fax: (204) 948-2010
Email: richard.perrault@gov.mb.ca
Or visit the website at: http://www.edu.gov.mb/aed/abidentity.html

Student Name (please print)_____

Parent/Guardian Signature_____

PLEASE RETURN THIS COMPLETED FORM TO YOUR CHILD'S SCHOOL.

PLEASE READ THIS INFORMATION BEFORE SIGNING THE REGISTRATION FORM

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FIPPA)

The personal information collected on this form is part of the Division's registration process and is authorized under the provisions of the Public Schools Act, The Freedom of Information, and Protection of Privacy Act, and the Personal Health Information Act. The personal information will be used to provide an educational program and ensure a safe and secure school environment.

Once the information is collected and compiled, Turtle Mountain schools believe the uses listed below are part of a vital, healthy and functioning school and participation of all students is important and encouraged. Here are activities where the information may be used:

- the use of student names, photos and comments in the school calendar, newsletter, yearbook, graduation book or other school publications
- taking of individual, class, team or club photos for school purposes
- the use of student names on artwork or other creative work or material of student displayed at school or school board sites or at school or school board sponsored display in the community
- the use of student names in honour rolls, graduation ceremonies, scholarship or other awards within the division or school board
- the use of student names and academic information necessary for determining eligibility or suitability for provincial, federal or other types of awards or scholarships in the event the board applies on a student's behalf
- the use of student names, addresses, phone numbers and special medical conditions for the purpose of providing a safe environment for the student
- the use of student names, related contact information and telephone numbers for absenteeism checks/storm billets etc.
- the taking of photos/videos of classroom or other school activities where the material will be used within the school. (Where individual students are identified or interviewed and the material will be used outside the school, a separate and specific consent will be required. You will be contacted prior to this event taking place.

If you have any questions or concerns regarding the collection and the intended purposes, please contact the principal of the school your child attends.

This registration form is a legal document. It must be accurate and complete.

All information will be treated confidentially.

Before a student can be admitted by a school, a student registration form must be completed in its entirety and signed by the parent or legal guardian, or by the student if 18 years of age. The student registration form is used to enrol a student who is new to Turtle Mountain School Division, or who has returned to the Division.

The registration form is also used when important information has changed. Such as:

- legal name of the student or parent/guardian
- address of the parent/guardian
- legal relationship to student

Declaration by Parent/Legal Guardian/or student if 18 years of age:

I have read the above information, and understand the purpose for which it is collected.

I certify the information provided by me to be accurate and complete.

Date: _____ **Signature:** _____
Parent/Legal

TURTLE MOUNTAIN SCHOOL DIVISION	6 - D

BUS STUDENTS

☐ **In-Town** ☐ **Out of Town**

The Turtle Mountain School Division will be providing transportation for the school year. For In-town bus students this privilege is dependent upon availability of seating. Priority will be given to students in grades K-6.

Student(s) Name(s): _____

_____

_____

Grade(s): _____

Street Address: _____

Legal Land Description: _____

Bus Stop Location: _____

When transportation needs to start: _____

Name of Parent(s)/Guardian(s): _____

Lives With: _____

(Please specify dates if shared custody) _____

Medical Conditions: _____

Phone Number: _____

Email address: _____

(We will respond to your request by email.)

_____ _____

Signature of Parent/Guardian Date

PARENT MEDIA RELEASE FORM FOR GRADE 7-12 STUDENTS

STUDENT ACCEPTABLE USE AGREEMENT

A. Internet Use Parent Advisory

Turtle Mountain School Division strongly believes that the internet provides a valuable resource that teachers will use as a means to extend and enhance the learning experiences in the classroom. As such, you may expect your child to have regular access to the technology available in their school. Please be advised that access to Division computers will also include supervised access to the internet. Turtle Mountain School Division will not be held responsible for supervising students who access the internet on their own for purposes other than classroom educational activities.

Access to the Internet provides students with opportunities to utilize interactive tools and sites on public websites that benefit learning, communication and social interaction. Students will be held accountable for the use of any information posted on these sites if it negatively affects others. To prevent students from using digital technology or electronic communication to harm others, rules are in place and discipline may be taken if the rules are not followed. Teachers may recommend and use public interactive sites that, to the best of their knowledge are legitimate and safe. Because these sites are public all students must use their discretion when accessing information, storing and displaying work on the site. Teachers will provide students with guidance in this area. This applies to Turtle Mountain School Division owned devices as well as student owned devices using the Turtle Mountain School Division network. Turtle Mountain School Division will not be held responsible for information that students voluntarily choose to share about themselves. Further, students may be issued Turtle Mountain School Division (tmsd) email accounts for the purposes of online communication with staff/students.

In addition, and in compliance with Policy H-1 (Student Conduct) as well as Bill 18 of the Public Schools Act (Safe and Inclusive Schools), students must agree to maintain appropriate and safe online communication whether in or outside of school and including the use of personal devices. Any form of cyberbullying, defaming, or humiliating other students is unacceptable. This includes the use of any social media, text messaging, or any other form of electronic communication. Failure to act appropriately will result in action being taken by school administration including potential disciplinary consequences.

B. Print & Digital Media Release

Turtle Mountain School Division recognizes that print and digital media and the internet provide an ideal means to showcase and promote School and Divisional activities and share student work with other students, parents/guardians, staff and the global community.

At the same time, however, the Division remains committed to protecting the privacy and safety of all students. For this reason, the Division has established a procedure for the publication, broadcast and distribution of digital media
.

1. Publication of Student Photos & Student Work Samples
   Student photographs or samples of student work may appear in the web version of the school newsletter, the school website or its associated teacher websites only with prior permission from the parents/guardians.

2. Publication of Student Names
   Students appearing in photographs may only be identified by first name in any format being published to the internet or distributed to the greater community. This would include student names appearing in, but not limited to...
   a. the web version of the school newsletter

b. the school website or its associated teacher websites
c. student, classroom or teacher authored multimedia content
d. Divisional promotional material (ie. Turtle Mountain School Division fall and spring publication)

NOTE: In situations where a student is being recognized for a local, provincial and/or national award, both first and last names may be used.

STUDENT ACCEPTABLE USE/PARENT MEDIA RELEASE FORM FOR GRADE 7-12 STUDENTS

Student Acceptable Use Agreement

I fully understand and agree to comply with the Division policy regarding my responsibilities as a Turtle Mountain School Division student as they pertain to my use of Information Technology both within and outside school.

School: _____

Student Name: _____ Grade: _____

Student Signature: _____

As a parent or guardian of the above student, I support the Division policy and agree that access to technology as provided by the School Division is to be used for educational purposes only. *(Parent or guardian signature required for students less than 18 years of age)*

Name of Parent or Guardian: (Print): _____

Signature of Parent or Guardian: _____

Date: _____

Publication & Distribution of Multimedia Content

Student, classroom or school created multimedia content may only be published to the web and/or distributed with prior permission from the parents/guardians. (For example, student, classroom or teacher authored multimedia content... classroom presentations, science fair projects, audio or video podcasts)

Please check one option and sign below:

____**YES, I DO** grant Turtle Mountain School Division permission to publish my child's name, photograph and samples of my child's work as per the protocols outlined above for the purposes of recognizing my child's accomplishments or publicizing and promoting school activities.

____**NO, I DO NOT** grant Turtle Mountain School Division permission to publish my child's name, photograph and samples of my child's work as per the protocols outlined above for the purposes of recognizing my child's accomplishments or publicizing and promoting school activities.

Name of Parent or Guardian (Print): _____

Signature of Parent or Guardian: _____

Date: _____

Note: Once dated and signed, this form shall remain in effect for the current school year or until consent is revoked. You may, at any time, amend this form by notifying (in writing) the school principal of the change. Note that consent of parents/guardians may be withdrawn at any time.

PRAIRIE MOUNTAIN HEALTH

Authorization for Release of Information to Public Health

Dear Parent/Guardian,

Please complete this form and return as directed below.

I, _____, hereby authorize the Public Health Nurse to access my
(Name of Parent/Guardian)

child/children's immunization record/s, for the purpose of obtaining their immunization history and offering recommended vaccines.

Student's Name	Date of Birth	Personal Health Information Number (PHIN)	School Attending	Grade

Parent/Guardian Names: _____

Address: _____

Phone Number: Home_____ Work _____ Cell _____

Name, Phone Number and Address of School Transferred From or Previously Attended:

_____

_____

If from out of province, please include a copy of your child's immunization record if possible.

NOTE: If your child has received immunizations from the local Public Health Nurse in the community where your child is attending school, you can disregard this letter.

_____ _____
(Parent/Guardian Signature) (Date)

Please fax or mail this completed form and immunization record if available to:

Prairie Mountain Health Immunization Coordinator
Fax: (204) 522-8559

Mail: Box 459
Melita Health Centre
Melita, MB R0M 1L0

PRAIRIE MOUNTAIN HEALTH

Community Program Representative ☐

UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

Review application, complete and sign in ink – to be completed ANNUALLY.

The purpose of this form is to identify the child's specific health care and if applicable, 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. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

Section I – To be completed by the community program

Type of community program *(please √)*	Community Program Name:	Location of Service: ☐ Same as on left
☐ School ☐ Licensed child care ☐ Respite ☐ Recreation program ☐ Other: _____	Contact person: Phone: Fax: Email: Mailing address: Street address: City/Town: Postal Code:	Contact person: Phone: Fax: Email: Mailing address: Street address: City/Town: Postal Code:

Section II - Child information - to be completed by parent

Last Name | **First Name** | **Birthdate** (Month (print) D D Y Y Y Y)

Preferred Name (Alias) | **Age** | **Grade** | **Gender** ☐ M ☐ F ☐ Other

Does your child ride the bus? ☐ YES ☐ NO

Does your child have any of the following listed health concerns? ☐ YES ☐ NO **(check (√) one)**

➢ If you have answered **NO**, please sign here and return this form to the community program.

_____ _____ _____

Parent/ Legal Guardian NAME *Parent/Legal Guardian SIGNATURE* *DATE (MON/DD/YYYY)*

➢ If you have answered **YES**, please complete the remainder of the form **including Section III**.

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

☐ YES ☐ NO **Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)**
- ☐ YES ☐ NO Does the child bring an injector to the community program?

☐ YES ☐ NO **Asthma (administration of medication by inhalation)**
- ☐ YES ☐ NO Does the child bring reliever medication (puffer) to the community program?
- ☐ YES ☐ NO Does your child know **when** to take their reliever medication (puffer) e.g. can recognize signs of asthma?
- ☐ YES ☐ NO Can your child take their reliever medication (puffer) **on their own**?
- **IF NO**, describe what your child needs help with:_____

☐ YES ☐ NO **Seizure disorder What type of seizure(s) does the child have?** _____
- ☐ YES ☐ NO Does the child require administration of rescue medication? ☐**Lorazepam** ☐**Midazolam**
- ☐ YES ☐ NO Does the child require the use of a vagal nerve stimulator (wand)?

☐ YES ☐ NO **Diabetes What type of diabetes does the child have?** ☐ **Type 1** ☐ **Type 2**
- ☐ YES ☐ NO 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 glucose emergencies that require a response?

☐ YES	☐ NO	**Ostomy Care**	
		☐ YES ☐ NO	Does the child have an ostomy/stoma?
		☐ YES ☐ NO	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	**Gastrostomy Care**	
		☐ YES ☐ NO	Does the child have a gastrostomy tube? Type of tube: _____
		☐ YES ☐ NO	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 program?
☐ YES	☐ NO	**Clean Intermittent Catheterization (CIC)**	
		☐ YES ☐ NO	Does the child require CIC?
		☐ YES ☐ NO	Does the child require assistance with CIC at the community program?
☐ YES	☐ NO	**Pre-set Oxygen**	
		☐ YES ☐ NO	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)**	
		☐ YES ☐ NO	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	**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? _____
☐ YES	☐ NO	**Bleeding Disorder (e.g., von Willebrand disease, hemophilia)**	
			What type of bleeding disorder has the child been diagnosed with? _____
☐ YES	☐ NO	**Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)**	
			What type of steroid dependence has the child been diagnosed with? _____
☐ YES	☐ NO	**Osteogenesis Imperfecta (brittle bone disease)**	What type? _____

Section III - Authorization for the Release of Medical Information

In accordance with *The Personal Health Information Act* (PHIA),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 health care provider, 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: _____ ***Child's PHIN:*** _____

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.

_____	_____	_____
NAME (PRINT) *Parent/ Legal Guardian*	***SIGNATURE*** *Parent/Legal Guardian*	*DATE (MMM/DD/YYYY)*

Mailing Address: _____ City/Town: _____ Postal Code: _____

Work/Daytime Phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____

PRAIRIE MOUNTAIN HEALTH

INDIVIDUAL HEALTH CARE PLAN (IHCP)
ASTHMA (2)

Name:		**Birthdate:** yyyy/mmm/dd	**Photo**
School/Community Program:			
Grade:	**MHSC:**	**PHIN:**	
MedicAlert™ bracelet worn? ☐ Yes ☐ No	**Does the child ride the bus?** ☐ Yes Bus No. _____ ☐ No		

Parent/Guardian Name:	**Home Phone No.:**	**Daytime Phone No.:**	**Cell Phone No.:**
Parent/Guardian Name:	**Home Phone No.:**	**Daytime Phone No.:**	**Cell Phone No.:**
Alternate emergency contact:	**Home Phone No.:**	**Phone No.:**	**Cell Phone No.:**
Allergist:		**Phone No.:**	
Pediatrician/Family Doctor:		**Phone No.:**	

TRIGGERS: List items that most commonly trigger your child's asthma.

RELIEVER MEDICATION (or bronchodilator) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if asthma episode occurs.

What reliever medication has been prescribed for your child? (CHECK ONE)	☐ Salbutamol (e.g. Ventolin®, Novo-Salmol®) ☐ Budesonide (e.g. Symbicort®) ☐ Other:_____
How many puffs of reliever medication are prescribed for an asthma episode? (CHECK ONE)	☐ 1 puff ☐ 1 or 2 puffs ☐ 2 puffs ☐ Other: _____
Where does your child carry his/her reliever medication?	☐ fanny pack ☐ purse ☐ backpack ☐ other _____
Does your child need help when using reliever medication?	☐ Yes What kind of help? _____ ☐ No

CIRCLE the type of medication device your child uses for <u>reliever medication</u>:


Metered dose inhaler (MDI)


MDI with Aerochamber®


MDI with Aerochamber® mask


Turbuhaler®

_____
other

The Individual Health Care Plan and emergency medication should accompany the child on excursions outside the facility.

Name: _____

Birthdate: _____

PHIN: _____

STANDARD HEALTH CARE PLAN (SHCP)
ASTHMA

IF YOU SEE THIS: 	DO THIS:
Signs of an asthma episode: ▪ Coughing ▪ Wheezing ▪ Chest tightness ▪ Shortness of breath ▪ Increase in rate of breathing	1. Remove the child from triggers of asthma (e.g. exercise, cold air, smoke). 2. Have child sit down. 3. Ensure the child takes reliever medication (blue cap). 4. Encourage slow deep breathing. 5. Monitor child for improvement.
Emergency Situations: ▪ Reliever medication has been given and there is no improvement of asthma symptoms in 5 minutes ▪ Greyish/bluish color in lips and nail beds ▪ Inability to speak in full sentences ▪ Heaving of chest or chest sucking inward ▪ Shoulders held high, tight neck muscles ▪ Cannot stop coughing ▪ Difficulty walking If asthma symptoms are severe, the child may NOT be wheezing as there is not enough air moving in the lungs to generate a wheeze.	1. Activate 911/EMS. 2. Give reliever medication every 5 minutes. 3. Notify parent/guardian. 4. Stay with child until EMS personnel arrives
Signs that asthma is not controlled **If staff become aware of any of the following situations, they should inform the child's parent/guardian.** ▪ Asthma symptoms prevent child from performing normal activities. ▪ Child appears to be experiencing more frequent coughing, shortness of breath or wheezing. ▪ Child is using reliever medication more than 3 times per week to relieve asthma symptoms. An exception to this includes the use of reliever medication before exercise to prevent exercise induced asthma symptoms, which then may be used up to once a day.	

I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.
Parent/guardian signature: _____ **Date:** _____ yyyy/mmm/dd

I have reviewed the above plan to ensure it provides the community program with required information.
Nurse signature: _____ **Date:** _____ yyyy/mmm/dd

I have received the above plan and have notified appropriate staff.
Program Designate signature: _____ **Date:** _____ yyyy/mmm/dd

☐ **Instruction sheet for medication device attached**

FOR OFFICE USE ONLY:

PRAIRIE MOUNTAIN HEALTH
SANTÉ PRAIRIE MOUNTAIN

ANAPHYLAXIS
INDIVIDUALIZED HEALTH CARE PLAN

Child name:		**Birth date:**
Community program name: **Grade:**		**MedicAlert™ identification worn ?** ☐ **YES** ☐ **NO**
Parent/guardian name:		
Home #:	**Cell #:**	**Work #:**
Parent/guardian name:		
Home #:	**Cell #:**	**Work #:**
Alternate emergency contact name:		
Home #:	**Cell #:**	**Work #:**
Allergist:		**Phone #:**
Pediatrician/Family doctor:		**Phone #:**

Life-threatening allergens

Other allergies (non life-threatening):

Adrenaline auto-injector prescribed for child	Type of device ☐ EpiPen® ☐ Allerject™	Dosage ☐ 0.3 mg ☐ 0.15 mg	Location ☐ Fanny pack or belt ☐ Backpack ☐ Purse ☐ Other _____

It is recommended that the adrenaline auto-injector is with the child during attendance at the community program. Antihistamines are NOT used in the management of life-threatening allergies in community program settings.

Child has a back-up adrenaline auto-injector at the community program. ☐ YES Location _____ ☐ NO

OTHER INFORMATION ABOUT MY CHILD'S LIFE THREATENING ALLERGY THAT THE COMMUNITY PROGRAM SHOULD KNOW:

The Health Care Plan and emergency medication should accompany the child on excursions outside the facility.

PRAIRIE MOUNTAIN HEALTH
SANTÉ PRAIRIE MOUNTAIN

ANAPHYLAXIS
EMERGENCY RESPONSE PLAN

Name:	**Birth date:**
IF YOU SEE THIS →	**DO THIS**

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

When remembering the signs of anaphylaxis, think F.A.S.T (Face, Airway, Stomach, Total Body)

Face
- red watering eyes
- runny nose
- itchiness
- redness, swelling of face, lips & tongue

Airway
- throat tightness
- change of voice
- difficulty swallowing
- difficulty breathing
- coughing
- wheezing

Stomach
- vomiting
- diarrhea
- cramps

Total body
- swelling
- hives
- itchiness
- sense of doom
- change in behavior
- pale or bluish skin
- dizziness
- fainting
- loss of consciousness

1. Give adrenaline auto-injector (EpiPen or Allerject).
   i. Secure child's leg.
   ii. Identify site on outer middle thigh.
   iii. Grasp adrenaline auto-injector in fist and remove safety cap(s).
   iv. Firmly press tip into the thigh at a 90º angle until you hear a click.
   v. Hold in place for a slow count of 5.
2. Activate 911/EMS.
3. Notify parent/guardian.
4. If signs of anaphylaxis persist or recur, give backup adrenaline auto-injector (if available) every 5 to 15 minutes.
5. Stay with child until EMS personnel arrive.
6. Discard adrenaline auto-injector safely or give to EMS personnel.

<u>Risk reduction strategies</u> are the only way to prevent anaphylaxis. Although it is not possible to achieve complete avoidance of allergens in community program settings, it is important to reduce exposure to life-threatening allergen(s). Please contact the community program if you have any questions about the risk reduction strategies that are implemented in their facility. School division policy may be found on their website.

I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.

Parent/guardian signature:_____ **Date:** _____

I have reviewed the above plan to ensure it provides the community program with required information.

Nurse signature:_____ **Date:** _____

Documentation
