**LIFE THREATENING ILLNESS PACKAGE & PLAN**

**Based on SABRINA’S LAW: An Act to Protect Anaphylactic Pupils, 2005.**

1. Provide the centre with at least one current epinephrine auto-injection kit, inhaler, or Dr prescribed life threatening medication (Parents should keep a log of expiry dates and replace outdated auto injectors and so will the Centre)
* Auto-injector/inhaler must be in a container labeled with the child’s name and prescription details.
* The auto-injector/inhaler will be easily accessible in the Preschool kitchen cupboard or in Before and After School Program, with the child at all times.
* Children with venom allergies (e.g. bee stings) have their auto –injector at the centre during bee season)
1. Parent/Guardian must meet with a childcare staff person and provide training. That staff will train the rest of the team.
* Provide your child with allergen free food products if required (You will need to provide a signed letter and follow snack protocols in our policies ie labeled container,).
* Teach your child to communicate clearly to an adult that they are in distress and for older children remind them to carry their auto-injector/puffer on their person at all times and wearing their Medic Alert identification, to not share utensils or containers and the importance of hand washing.
* Tell children not to go off alone (e.g. washroom) unaccompanied if they are experiencing an allergic reaction or feeling unwell. If they lose consciousness they will not be able to ask for help.

**REQUEST & CONSENT for the ADMINISTRATION of**

**Epinephrine/Inhalers/Dr Prescribed Medication**

This form is completed when the centre agrees with the parental request to administer medication for life threatening allergies. A new form is required:

 a) at the initiation of this process; b) when the medication changes. Staff will administer medication according to the information in this form only.

**STATEMENT OF UNDERSTANDING**

As the Parent(/Guardian of ( student name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who attends programs at Oak Park Neighbourhood Centre. I (we) accept, endorse and agree to comply with the following terms and/or conditions pertaining to my(our) request for OPNC employees to provide my(our) child with medication prescribed under the authority of the doctor named in the “Individualized Treatment Plan”. Specifically, I/we understand and accept that:

1. I/we are responsible for providing and maintaining at least one dose of required medication (Epinephrine auto injector, Inhaler or Dr prescribed life threatening medication.
2. I/we are responsible for providing a copy of the prescription and instructions from the child’s physician or nurse.
3. Oak Park Neighbourhood Centre employees are not trained health professionals and hence may not recognize the symptoms of the child’s medical condition. I/we realize that the centre does not have the facilities nor the qualified and trained health professionals to ‘wait and see’ what happens before administering the prescribed medication.
4. The Emergency Action plan following the best advice from Anaphylaxis Canada is to:
	* + **A** Administer the auto-injector immediately at the first sign of symptoms;
		+ **C** Call 911
		+ **T** Transport to hospital by ambulance.

The Action plan for Puffers and Emergency medication is to administer them if symptoms are observed.. If after

minutes the child is still having difficulty breathing then 911 will be called.

Epinephrine auto-injectors, inhalers and Dr prescribed medication supplied to the centre will be in clearly labeled containers which display the name of your child, the name of prescribing doctor, and the expiry date

1. Request that the prescribed medications listed in the Individual Student Plan of this document be administered to my child according to the prescription information provided by the prescribing physician.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There has been no change in condition or treatment strategy from previous year. Parent initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**INDIVIDUALIZED TREATMENT PLAN**

**To be completed by the parent of the child and parent to train a staff person who in turn trains the team. This plan to be reviewed with all staff and placement students and posted for quick access.**

# CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Prescribed Medication & Dr guidelines on administering.****Ie. Amount and 2nd dose & timing** |  |
| **When is Medication required?****How Must the allergen come in contact for reaction?****(ie Ingestion, contact with hands, face other?)** |  |
| **Monitoring Strategies & expiry date.****Review plan every 6mth and document** | Lead teacher checks the medication in centre’s possessionExpiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Fall, Winter, Spring, Summer- 4 times a year

**Date & Initial \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_** |
| **Avoidance Strategies & Other Details like Triggers** |  |
| **Appropriate treatment****Emergency Procedure** | Administer prescribed medication kept in kitchen cupboard and then log information as soon as possible on the “Medical Authorization and Administration Record”**Asthma****A** Administer inhaler immediately at the first sign of symptoms**Anaphalctic****A** Administer the auto-injector immediately at the first sign of symptoms;A second dose may be administered within 10-15 min. or sooner, if symptoms have not improved or have worsened **C** Call 911- do not leave child alone. Call parent**T** Transport to hospital by ambulance.**Life Threatening Prescribed Medication****A** Administer prescribed medication when child has symptoms. |

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Centre supervisor/operator/designate Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Initials-**

**INDIVIDUALIZED TREATMENT PLAN**

Student’s photo

2 x 2.5

*(Incl. Anaphylactic & Asthmal)*

*Early recognition of symptoms and immediate treatment could save this person’s life.*

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis (Anaphylactic & to what)\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Triggers/Precaution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribed Medication & location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A person having a life threatening issue might have ANY of these signs and symptoms:**

(Highlight all that apply)

•**FACE** itching & swelling of the lips, tongue, face or mouth, watery eyes, nasal congestion, runny itchy nose,

•**RESPIRATORY** itching, tightness in the throat, hoarseness, cough, wheezing, shortness of breath, chest pain,

•**SKIN** hives, itchy rash, warmth, redness, swelling of extremities, pale/blue colour

•**STOMACH** nausea, abdominal cramps, vomiting, and/or diarrhea

•**HEART**\* weak pulse, passing-out, dizzy, light headed, shock,

•**OTHER**\_headache, anxiety, tired, fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* 1. **Give medication** at the first sign of a reaction and follow the treatment plan . Give a second dose if Doctor recommended in the plan.
	2. **Never leave the child unattended.**
	3. **After Epi Pen use, medication administration or if asthma condition does not improve after inhaler Call 911.** Tell dispatcher that someone is having a life-threatening issue. (Asthma emergency: cannot speak more than 5 words, lips or nail beds are blue, breathing is difficult & fast, skin on neck sucked in with breath) Request an ambulance.
	4. **Call contact person.**

**Emergency Contact Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Relationship** | **Home Phone** | **Work Phone** | **Cell Phone** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  | Doctor/Allergist |  |  |  |

*The undersigned patient, parent or guardian authorizes any adult at Oak Park Neighbourhood Centre to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient/Parent/Guardian signature Date Physician’s signature (optional*

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off activation cap.

2. Hold near outer thigh (always apply to thigh).

3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and sent with emergency personnel. Massage the injection area for 10 seconds.

OPNC MEDICAL AUTHORIZATION AND ADMINISTRATION RECORD

Instructions:

OPNC staff will not administer medication unless it is life saving ie puffers for asthma, Dr approved medication for life threatening issue, or Epipens. Parents are required to administer medication before or after our programs when not a life threatening illness. Medication is administered to a child only where a doctor and parent give written authorization with a schedule that sets out the times and amounts

1. Medications are to be in their original containers with the child's name, DIN#, Dosage Req., instructions for storage and administration, date of purchase and expiry date of medication.
2. Store life saving medications as directed in a sealed container out of reach of children, except for Epipens/Autoinjectors
3. Complete this form for each medication

**ADMINISTRATION RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I authorize the administration of life saving medication,  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Medication )to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Child)by Oak Park Neighbourhood Centre StaffDosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is medication Indicated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2nd dose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date OPNC Signature Date | Time Given | Amount Given | Staff Initial | Comments/ObservationsNote -Expiry date & Date Returned |
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The information requested is collected for the purposes of supporting the health and welfare of each child and ensuring the safety of each child. The information is collected pursuant to the authority of the *Day Nurseries Act*, R.S.O. 1990, c. D.2, as amended, and the regulations thereunder. For further information relating to the collection of personal information, please contact the Executive Director of OPNC 905-257-6029.