CARE PLAN FOR LONG-TERM CONDITIONS

NAME OF STUDENT: _____
FIRST NAME SURNAME

DATE OF BIRTH: _____ - _____ - _____
DATE MONTH YEAR

CARE CARD NO: _____

PROGRAM:
☐ GDC ☐ JKC
☐ ITC ☐ SUMMER
☐ OSC

CHILD'S DOCTOR: _____ **PHONE NOS:** _____

MOTHER'S NAME: _____ **PHONE NOS:** _____

FATHER'S NAME: _____ **PHONE NOS:** _____

EMERGENCY CONTACT: _____ **PHONE NOS:** _____

LONG-TERM CONDITION(S): _____

please specify **all** long term conditions with details e.g. allergy to...; asthmatic condition deteriorates when...; autistic...; ADHD...; etc. please provide child's assessments, support plans, etc. if/when available. (Please continue on back of page if required.)

MEDICATION (if any) & DOSAGE: _____

SPECIAL INSTRUCTIONS IN ADDITION TO PG. 2 FOR MEDICAL & PG. 3 FOR BEHAVIOURAL CONDITION(S):

I/We agree that this plan represent(s) my/our wishes and consent, that I/we will be involved in updating it and that I will be given the opportunity to review any update:

_____
Signature(s) of Parent(s) or Legal Guardian Date

I/We give consent to share a copy of this plan & its updates with the support team. I/we understand that this consent will expire on_____ or one year from the date, whichever is earlier.

_____
Signature(s) of Parent(s) or Legal Guardian Date

MEDICAL CONDITION(S) ~ (IN CONJUCTION WITH PG.1)

For a suspected or active allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

BEHAVIOURAL CONDITION(S) ~ SUPPORT/ACTION PLAN (IN CONJUCTION WITH PG.1):

FAMILY MEMBERS (OTHER THAN PARENTS):

1 _____

Name Relationship Age

2 _____

Name Relationship Age

3 _____

Name Relationship Age

ADDITIONAL SUPPORT/SERVICES INVOLVED:

1 _____

Name Designation From

2 _____

Name Designation From

3 _____

Name Designation From

4 _____

Name Designation From

DEVELOPMENTAL INFORMATION: _____

ASSESSMENT INFORMATION: _____

GOALS INCLUDING PRIORITIES & CONCERNS: _____

HEALTH & SAFETY INFORMATION: _____

CHILD'S STRENGTHS & INTERESTS: _____

FAMILY'S STRENGTHS & INTERESTS: _____

CULTURAL/SPIRITUAL CONSIDERATIONS: _____