



CARE PLAN FOR LONG-TERM CONDITIONS

NAME OF STUDENT:

FIRST NAME	SURNAME	
DATE	MONTH	YEAR

PROGRAM:	
<input type="checkbox"/> GDC	<input type="checkbox"/> JKC
<input type="checkbox"/> ITC	<input type="checkbox"/> SUMMER
<input type="checkbox"/> OSC	

DATE OF BIRTH:

CARE CARD NO:

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 CONJUNCTION 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**
- Stay with student; alert emergency contacts.
- 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 CONJUNCTION 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: _____
