



## INDIVIDUALIZED PLAN AND EMERGENCY PROCEDURES FOR A CHILD WITH AN ANAPHYLACTIC ALLERGY

Child's Name: \_\_\_\_\_

Child's Date of Birth (dd/mm/yyyy): \_\_\_\_\_

List of allergen(s)/causative agent(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Asthma: Yes (higher risk of severe reaction)    No

Location of medication storage: \_\_\_\_\_

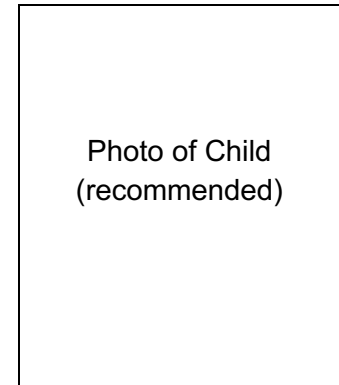
**2 auto injectors must be on site at all times**

**Epinephrine auto-injector expiry dates**

(dd/mm/yyyy): \_\_\_\_\_ (dd/mm/yyyy) \_\_\_\_\_

**Other emergency medications\*:** (i.e. Benadryl) \_\_\_\_\_

*please also fill out additional medication administration form for Benadryl or other medication*



**Staff will review the expiry date of medication each September and January of each year**

**Emergency Services Contact Number:** 911

Special Instructions:

<p><b>CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A <u>NON-LIFE-THREATENING</u> ANAPHYLACTIC REACTION:</b> <i>(specific to the child, e.g. wheezing and itchy skin)</i></p>	<p><b>CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A <u>LIFE-THREATENING</u> ANAPHYLACTIC REACTION:</b> <i>(specific to the child, e.g. inability to breathe, sweating)</i></p>
<p><b>DESCRIPTION OF PROCEDURE TO FOLLOW IF CHILD HAS A NON-LIFE THREATENING ANAPHYLACTIC REACTION:</b></p>	<p><b>DESCRIPTION OF PROCEDURE TO FOLLOW IF CHILD HAS A LIFE-THREATENING ANAPHYLACTIC REACTION:</b></p>
<p><b>STEPS TO REDUCE RISK OF EXPOSURE TO CAUSATIVE AGENT/ALLERGEN:</b> <i>(e.g. nut-free environment)</i></p>	
<p><b>ADDITIONAL NOTES (if applicable):</b> <i>(e.g. use of other emergency allergy medication(s) to implement the emergency procedures)</i></p>	

- *\*Written parental authorization for the administration of drugs and medications must be completed and implemented for medications other than epinephrine auto-injectors.*
- *Each child with an anaphylactic allergy requires their own individualized plan. If significant changes and updates are required to this individualized plan, a new individualized plan must be completed.*
- *Children's personal health information should be kept confidential.*

**Parental Statement**

I \_\_\_\_\_ (parent/guardian) hereby give consent for my child \_\_\_\_\_ (child's name) to:

(check which option applies to your child):

carry their emergency allergy medication in the following location (e.g. blue fanny pack around their waist):

\_\_\_\_\_  
 self-administer their own medication in the event of an anaphylactic reaction

or

- request all medication be carried by staff on duty

**AND/OR**

I \_\_\_\_\_ (parent/guardian) hereby give consent to any person with training on this plan at the home child care premises to administer my child's epinephrine auto-injector and/or asthma medication and to follow the procedures set out in my child's Individualized Anaphylaxis Plan and Emergency Procedures.

Parent/Guardian Signature: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact Name	Relationship to Child	Primary Phone Number	Additional Phone Number

**HEALTHCARE PROFESSIONAL CONTACT INFORMATION: (optional)**

Contact Name	Primary Contact Number

**SIGNATURE OF HEALTHCARE PROFESSIONAL (optional)**

X	Date:
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I confirm that this plan has been reviewed with the Childcare Director or Designate.

**SIGNATURE OF PARENT/GUARDIAN (required)**

Print name:	Relationship to Child:
X	Date: