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

Child's Name: _____

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

Photo of Child (recommended)

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/yyy) _____

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:

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

- *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:

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: