Anaphylaxis Plan

Child's Name: _____ Room: _____

This child has a life-threatening allergy to the following:

_____

Any products containing these allergens in any form or amount may be life-threatening. Any products that may have come in contact with an allergen or products with a "may contain" warning must be avoided.

PHOTO		**Name of Medication:**_____ **Dosage:**_____ **Expiry Date:**_____ **Primary location of Medication:**_____ **Epinephrine injectors must be carried/worn on school-age child at all times within The Village Children's Programs* **Second location if provided:**_____ ○ **Prescription label is directly on medication** ***Not on box**

Identify possible Anaphylactic Symptoms:

__ flushed face, hives, tingling in the mouth, swelling or itchy lips, tongue, eyes
__ tightness in throat, mouth , chest
__ difficulty breathing or swallowing, wheezing, coughing, choking
__ vomiting, nausea, diarrhea, stomach pains
__ loss of consciousness
__ fear and or panic
__ dizziness, unsteadiness, sudden fatigue, rapid heartbeat

List additional/other symptoms for your child: _____
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At the first sign of a known or suspected anaphylactic reaction:
****To be reviewed by parent who will then train a staff of The Village Children's Programs**

STEPS

1	**Give epinephrine injector**
2	**Call 9-1-1 Tell them someone is having a life-threatening allergic reaction.** **Give correct address and location of child**
3	**If provided, give a second dose of epinephrine as early as 5 minutes after first dose if no improvement**
4	**Call Emergency Contact person(s)**
5	**Go to the hospital immediately (by ambulance) even if symptoms are mild or have stopped**

Emergency Contact Information:

NAME	PHONE #1	PHONE #2	RELATIONSHIP

Child's Home Address:	

Physician's Name:	**Physician's Phone #:**

I, _____give consent to have treatment administered to my child:_____

I have trained_____ to administer the medication as well as on my child's individual plan.
(Staff's Name)

I authorize the staff above, to train all staff, students and volunteers on my child's individual plan, including the administration of medication.

Parent Signature _____ Date: _____

Parent input on Training and Emergency Plan:

_____

_____

_____

Suggested strategies: (list avoidance/safety rules and or strategies for your child if any)

_____

_____

_____

It is strongly recommended to have 2 epinephrine injectors at the child care centre for your child. This form will be posted in the required areas of the school/childcare. Please sign below to acknowledge posting information.

_____ _____

Parent Signature Date

Staff signatures indicating that they have been trained, are aware, understand this plan and will review it annually.

CHILD'S NAME_____

Staff Name	Signature	Date	Staff Name	Signature	Date

05/16