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: _____

Epinephrine auto-injector brand name: _____

Epinephrine auto-injector expiry date (dd/mm/yyyy): _____

Other emergency medications*: _____

Emergency Services Contact Number: _____

CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A NON-LIFE THREATENING ANAPHYLACTIC REACTION: *(specific to the child, e.g. wheezing and itchy skin)*	**CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A LIFE THREATENING 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)*	

Parental Statement

I _____ (parent/guardian) hereby give consent for my child _____ (child's name) to (check all that apply):

☐carry their emergency allergy medication in the following location : _____

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

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 initials: _____

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:

SIGNATURE OF PARENT/GUARDIAN (required)

Print name:	Relationship to Child:
X	Date: