# INDIVIDUALIZED PLAN AND EMERGENCY PROCEDURES

# FOR A CHILD WITH AN ANAPHYLACTIC ALLERGY

Child’s Name: Click here to enter text.

Child's Date of Birth (dd/mm/yyyy): Click here to enter text.

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

* Click here to enter text.

Asthma: [ ] Yes (higher risk of severe reaction) [ ] No

Location of medication storage: Click here to enter text.

Epinephrine auto-injector brand name: Click here to enter text.

Epinephrine auto-injector expiry date (dd/mm/yyyy): Click here to enter text.

Other emergency medications\*: Click here to enter text.

Emergency Services Contact Number: Click here to enter text.

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

## Parental Statement

I Click here to enter text. (parent/guardian) hereby give consent for my child

Click here to enter text.(child’s name) to (check all that apply):

[ ] carry their emergency allergy medication in the following location (e.g. blue fanny pack around their waist): Click here to enter text.

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

AND/OR

I Click here to enter text. (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 |
| --- | --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

## HEALTHCARE PROFESSIONAL CONTACT INFORMATION: (optional)

| Contact Name | Primary Contact Number |
| --- | --- |
| Click here to enter text. | Click here to enter text. |

### SIGNATURE OF HEALTHCARE PROFESSIONAL (optional)

|  |  |
| --- | --- |
| X  | Date:Click here to enter text. |

### SIGNATURE OF PARENT/GUARDIAN (required)

|  |  |
| --- | --- |
| Print name: | Relationship to Child:Click here to enter text. |
| X | Date: Click here to enter text. |