Little Giants Childcare Centre

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)

Annual Review by Parents:

Date:_____ Initial:_____

Date:_____ Initial:_____

Date:_____ Initial:_____

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	

Special Instructions:

- *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.