# INDIVIDUALIZED PLAN FOR A CHILD WITH AN ANAPHYLACTIC ALLERGY

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| Child’s Name:  |
| Child's Date of Birth (dd/mm/yyyy):  |
| List of allergen(s)/causative agent(s):  |
| Asthma: [ ] Yes (higher risk of severe airway reaction) [ ] No |
| Epinephrine auto-injector brand name and dosage:  |
| Epinephrine auto-injector expiry date (mm/yyyy): | **Location of Epinephrine:** [ ] On Educator or [ ]  On Child |
| Other emergency medications: | Location of medication storage: |

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| SIGNS AND SYMPTOMS OF A REACTION: (e.g. red rash on mouth and itchy skin) |
| SIGNS AND SYMPTOMS OF AN ANAPHYLACTIC REACTION: (e.g. airways closing, swelling of tongue) |
| PROCEDURE TO FOLLOW IF CHILD HAS A REACTION: (e.g. administer 1 teaspoon of Children’s Benedryl, observe symptoms, call parents) |
| PROCEDURE TO FOLLOW IF CHILD HAS AN ANAPHYLACTIC REACTION: (e.g. administer Epinephrine, call 911, call parents) |
| STEPS TO REDUCE RISK OF EXPOSURE TO CAUSATIVE AGENT/ALLERGEN: (e.g. nut-free environment) |

| Photo of Child(recommended) |
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## EMERGENCY CONTACT INFORMATION

| Contact Name | Relationship to Child | Primary Phone Number | Additional Phone Number |
| --- | --- | --- | --- |
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**PARENTAL STATEMENT**

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

[ ] self-carry their emergency allergy medication on their body.

[ ] 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 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.

[ ]  This plan has been created in consultation with the child’s parent / guardian.

### SIGNATURE OF PARENT/GUARDIAN (required)

|  |  |
| --- | --- |
| Print name: | Relationship to Child: |
| X | Date:  |

The following individuals participated in the development of this individual plan (optional):

|  |  |  |
| --- | --- | --- |
| First and Last Name | Position/Role | Signature |
|  |  |  |

This plan will be reviewed and updated annually or as needed.