



INDIVIDUALIZED PLAN AND EMERGENCY PROCEDURES FOR A CHILD WITH AN ANAPHYLACTIC ALLERGY

Child's Name:

Child's Date of Birth (dd/mm/yyyy):

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:

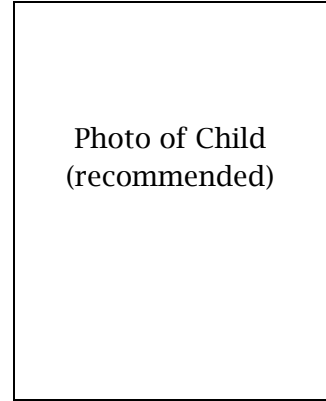


Photo of Child
(recommended)

Photo of Child (Recommended)

CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A NON-LIFE THREATENING ANAPHYLACTIC REACTION:	CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A LIFE THREATENING ANAPHYLACTIC REACTION:
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:	
ADDITIONAL NOTES (if applicable): (

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.

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:
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SIGNATURE OF PARENT/GUARDIAN (required)

Print name:	Relationship to Child:
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