CENTERED ON CHILDREN CHILD CARE CENTRE

Anaphylaxis Emergency Plan:___________________

(Name)

This child has a potentially life-threatening allergy (anaphylaxis) to:

☐ Peanuts	☐ Latex
☐ Tree Nuts	☐ Medication___________________________________
☐ Egg	☐ Insect Stings________________________________
☐ Milk	☐ Other ______________________________________

Food: The key to preventing an anaphylactic emergency is absolute avoidance of the allergen. People with food allergies should not share food or eat unmarked / bulk foods or products with a "*may contain*" warning.

Epinephrine Auto-Injector ("Epipen"): Expiry Date ___________________________

Location of Auto-Injector(s): ____

Dosage: ☐ **EpiPen Jr 0.15mg** ☐ **EpiPen 0.30mg**
☐ **Twinject 0.15mg** ☐ **Twinject 0.30mg**

☐ **Asthmatic**: Child is at greater risk. If child is having a reaction and has difficulty breathing, give ephinephrine auto-injector **before** asthma medication.

A person having an anaphylactic reaction might have ANY of these signs & symptoms:

- **Skin:** hives, swelling, itching, warmth, redness, rash
- **Respiratory (breathing):** wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay-fever-like symptoms (runny itchy nose & watery eyes, sneezing), trouble swallowing
- **Gastrointestinal (stomach):** nausea, pain/cramps, vomiting, diarrhea
- **Cardiovascular (heart):** pale/blue colour, weak pulse, passing out, dizzy / light-headed, shock
- **Other:** anxiety, headache, feeling of "impending doom"

Early recognition of symptoms & immediate treatment could save a child's life.

Act quickly. The first signs of a reaction can be mild, but symptoms can rapidly worsen:

1) **Give epinephrine auto-injector** at the first sign of a reaction occurring in conjunction with a known or suspected contact with allergen. Give a second dose in 10 – 15 minutes or sooner **IF** the reaction continues or worsens.
2) **Call 911:** Tell them a child is having a life-threatening allergic reaction – use the word "anaphylactic". Request an ambulance immediately.
3) **Call contact person**
4) **Escort child in ambulance** and remain with child until parent arrives.

Emergency Contact Information

Name	***Relationship***	***Home Phone***	***Work Phone***	***Cell Phone***

The undersigned parent or guardian authorizes any adult to administer epinephrine to the above named child in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the child's physician. I also consent to the posting of this plan in every room operated by ____________________ and to the sharing of this information with all staff, students and volunteers. I also consent to my child carrying her/his own Epi-pen.

___________________________	_______________	__________________________	_______________
Parent/Guardian Signature	Date	Physician's Signature	Date

Anaphylaxis Emergency Plan

Child's Address: ____________________ **Date of Birth**:____________________
____________________ **Home Telephone**:__________________
____

Emergency Action Plan: (To be filled in by parent)

Child Care Staff Roles and Responsibilities:

- Adhere to ______________________ Anaphylactic Policy
- Staff will conduct a check to confirm child (ren) have their required medication with them before each transition, (ie. moving from the classroom to the gym, leaving for school, etc.)
- Administer medications and/or instructions as set out in child's Individual Plan and Emergency Procedures
- Staff is to remain calm
- Staff will be debriefed
- Written report to be filled out by staff dealing with emergency
- Serious Occurrence to be filed

Parent Agreement

I______________________ acknowledge my participation in the development of the preceding Emergency Action Plan and agree to execute reliability the parent commitments listed within them.
I give my consent for the staff of ____________ Child Care Centre to execute the child care commitment as outlined within the plan.
In the event of an emergency, I authorize the child care staff to administer the designated medication and obtain medical assistance. I agree to assume responsibility for all costs associated with medical treatment and absolve _________ and its employees/volunteers of responsibility for any adverse reaction resulting from administration of the medication.

Parent Signature:______________________________ Date:____________________

TO BE REVIEWED ANNUALLY