



EMERGENCY CARE PLAN

ANAPHYLAXIS

PERMISSION TO ADMINISTER MEDICATION FORM IS STILL REQUIRED FOR ALL OTHER MEDICATIONS

Care plan for:	Today's Date:	Copy with Emergency form? (check box)	<input type="checkbox"/>
-----------------------	----------------------	--	--------------------------

Child's anaphylaxis triggers are:

<input type="checkbox"/> Peanuts	<input type="checkbox"/> Eggs	<input type="checkbox"/> Food additives	<input type="checkbox"/> Other (list): _____
<input type="checkbox"/> Tree nuts	<input type="checkbox"/> Shellfish	(list): _____	_____
<input type="checkbox"/> Milk	<input type="checkbox"/> Fish	<input type="checkbox"/> Medications	_____
<input type="checkbox"/> All dairy	<input type="checkbox"/> Insect stings	(list): _____	_____

Child's anaphylaxis symptoms are usually:

Skin: <ul style="list-style-type: none"> <input type="checkbox"/> Swelling (eyes, lips, face, tongue) <input type="checkbox"/> Hives or itching <input type="checkbox"/> Flushed face or body <input type="checkbox"/> Cold, clammy, sweaty skin 	Heart: <ul style="list-style-type: none"> <input type="checkbox"/> Pale/blue colour <input type="checkbox"/> Fainting or loss of consciousness <input type="checkbox"/> Weak pulse <input type="checkbox"/> Heart rate changes (fast/slow)
Breathing: <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty breathing/ swallowing <input type="checkbox"/> Coughing/choking <input type="checkbox"/> Nasal congestion or hay fever like symptoms (runny, itchy nose, watery eyes, sneezing) <input type="checkbox"/> Change of voice 	Stomach: <ul style="list-style-type: none"> <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach cramps <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea Other: (list) _____

Child's emergency treatment:

- 1. GIVE:** _____
At the first sign of a reaction occurring in conjunction with a known or suspected contact with allergen.
- 2. CALL 911**
- 3. CALL PARENTS**
- 4. Other instructions:** _____

Medication is stored (location):	
Antihistamine: (specify brand and dosage)	
Epinephrine Auto-injector: (include expiry date)	
Names of staff oriented to plan:	
Field trip plans:	

Sign below if you agree with above care plan

Signature of parent:		Date:	
Signature of Licensee:		Date:	