



# EMERGENCY CARE PLAN

## ANAPHYLAXIS

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

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

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

**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:** \_\_\_\_\_

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

**Sign below if you agree with above care plan**

<b>Signature of parent:</b>		<b>Date:</b>	
<b>Signature of Licensee:</b>		<b>Date:</b>	