



WEST END HOME CHILD CARE SERVICES

1411 Bloor Street West, Toronto, Ontario M6P 3L4 • Tel: (416) 537-4154 • Fax: (416) 537-2740

Anaphylaxis Emergency Treatment

Child's Name: _____ DOB: _____

Parent/Guardian: _____ Tel: _____

Parent/Guardian: _____ Tel: _____

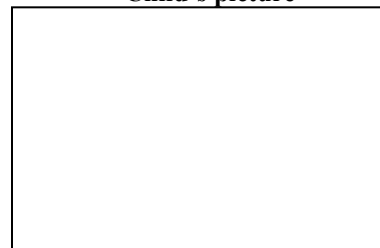
Doctors Names: _____ Tel: _____

Emergency contact: _____ Relationship: _____ Tel: _____

The above name child has Life Threatening Anaphylactic Allergies to:

Child's picture

check	Allergy
	FOOD:
	INSECT STING:
	LATEX:
	MEDICATION:
	DAIRY:
	SHELLFISH:
	OTHER:



Anaphylactic Symptoms:

check	Possible Symptoms	other/ additional symptoms
	Skin- hives, swelling, itching, warmth, redness or rash	
	Tightness of throat, horse voice, chest pain/ tightness	
	Difficulty breathing, wheezing, cough, nasal congestion	
	Vomiting, nausea, diarrhea, stomach pains, cramps	
	Loss of consciousness, pale, blue colour, weak pulse, dizzy	
	Fear and/ or panic, anxiety, headache	

Parents must Supply

	Epi Pen Expiry Date: _____ Location: _____
	Dosage: <input type="radio"/> Epi Pen Jr. 0.15 mg <input type="radio"/> Epi Pen 0.30 mg
	<input type="radio"/> Twin Ject 0.15 mg <input type="radio"/> Twin Ject 0.30 mg
Asthmatic	If child is having a reaction and has difficulty breathing, give Epi pen before asthma medication

ACTION PLAN

1. Give injection of Epi-pen at first signs of reaction occurring in conjunction with a known or suspected contact with allergen. Give a second dose in 10 to 15 minutes or sooner if the reaction continues to worsen. (note the time epi pen administered).
2. Call 911 and advise the dispatcher that a child is having an Anaphylactic reaction, ask for ambulance immediately
3. Stay with child and monitor symptoms
4. Call your home consultant, parent/ guardian or emergency contact person
5. Escort child to the hospital, even if symptoms subside entirely until parent arrives
6. Take the administered Epi-pen with you to the hospital

Parent/Guardian Signature

Date

Physician's Signature

Date

The undersigned parent/ guardian authorize the Day Care provider and volunteers 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 in the provider's home and to the sharing of this information with the home consultants providers household students and volunteers.

Parent/guardian Signature

Date



WEST END HOME CHILD CARE SERVICES

1411 Bloor Street West, Toronto, Ontario M6P 3L4 • Tel: (416) 537-4154 • Fax: (416) 537-2740

Anaphylactic Training Record

Child's Name: _____

Trainer's Name: _____

Date: _____

Trainer's Signature: _____

This signifies that we have been trained, read and will abide by (child's name) _____
Anaphylactic policy and Individual plan. This policy and Individual plan will be reviewed and signed
annually.

Staff / provider name	Date	Signature	Witness

Provider's Family/Parents	Date	Signature	Witness