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:

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

Child's picture

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: O Epi Pen Jr. 0.15 mg O Epi Pen 0.30 mg O Twin Ject 0.15 mg O 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 minuets 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

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Emergency Action Plan: (to be Filled out by parent/guardian)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Child Care provider role and responsibilities

Adhere to the anaphylactic policy
Provider will ensure that the Epi pen and any required medication is with the child before any transitions
Administer medication or instructions as set out in writing by parents
Provider to remain calm
Provider will be debriefed (make a report)
Written report (serious occurrence through CCLS) to be filled out by the home provider and the staff dealing with the emergency
Report to be in the file for 3 years.

Parent/Guardian Agreement

I _____ parent / guardian of _____ acknowledge my participation in the development of the Emergency Action Plan.

I authorize the home provider, staff, and residents of the home where day care is provider to administer the designated medication and obtain medical assistance. I agree to assume responsibility for all costs associated with medical treatment and absolve the home provider, staff, and residents of the home of any responsibility for any adverse reaction resulting from administration of the medication.

Parent Signature:_____ Date:_____

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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

Reviewed March 2020