Appendix A:
INDIVIDUALIZED PLAN AND EMERGENCY PROCEDURES FOR A CHILD WITH AN ANAPHYLACTIC ALLERGY

Child's Name: _____

Child's Date of Birth (dd/mm/yyyy): _____

List of allergen(s)/causative agent(s):

Asthma: ☐Yes (higher risk of severe reaction) ☐No

Location of medication storage: _____

Epinephrine auto-injector brand name: _____

Epinephrine auto-injector expiry date (dd/mm/yyyy): _____

Other emergency medications*: _____

Emergency Services Contact Number: _____

Photo of Child (recommended)

CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A NON-LIFE THREATENING ANAPHYLACTIC REACTION: *(specific to the child, e.g. wheezing and itchy skin)*	**CHILD'S SPECIFIC SIGNS AND SYMPTOMS OF A LIFE THREATENING ANAPHYLACTIC REACTION:** *(specific to the child, e.g. inability to breathe, sweating)*

Special Instructions:

- *Written parental authorization for the administration of drugs and medications must be completed and implemented for other medications.
- Each child with an anaphylactic allergy requires their own individualized plan. If significant changes and updates are required to this individualized plan, a new individualized plan must be completed.
- Children's personal health information should be kept confidential.

DESCRIPTION OF PROCEDURE TO FOLLOW IF CHILD HAS A NON-LIFE THREATENING ANAPHYLACTIC REACTION:	**DESCRIPTION OF PROCEDURE TO FOLLOW IF CHILD HAS A LIFE-THREATENING ANAPHYLACTIC REACTION:**
STEPS TO REDUCE RISK OF EXPOSURE TO CAUSATIVE AGENT/ALLERGEN: *(e.g. nut-free environment)*	
ADDITIONAL NOTES (if applicable): *(e.g. use of other emergency allergy medication(s) to implement the emergency procedures)*	

Parental Statement

I _____ (parent/guardian) hereby give consent for my child

_____ (child's name) to (check all that apply):

☐carry their emergency allergy medication in the following location (e.g. blue fanny pack around their waist):

☐self-administer their own medication in the event of an anaphylactic reaction

AND/OR

I _____ (parent/guardian) hereby give consent to any person with training on this plan at the After School Program to administer my child's epinephrine auto-injector and/or asthma medication and to follow the procedures set out in my child's Individualized Anaphylaxis Plan and Emergency Procedures.

Parent/Guardian initials: _____

EMERGENCY CONTACT INFORMATION

Contact Name	Relationship to Child	Primary Phone Number	Additional Phone Number

Special Instructions:

- *Written parental authorization for the administration of drugs and medications must be completed and implemented for other medications.
- Each child with an anaphylactic allergy requires their own individualized plan. If significant changes and updates are required to this individualized plan, a new individualized plan must be completed.
- Children's personal health information should be kept confidential.

Contact Name	Relationship to Child	Primary Phone Number	Additional Phone Number
Contact Name	**Relationship to Child**	**Primary Phone Number**	**Additional Phone Number**

HEALTHCARE PROFESSIONAL CONTACT INFORMATION: (optional)

Contact Name	Primary Contact Number

SIGNATURE OF HEALTHCARE PROFESSIONAL (optional)

X

SIGNATURE OF PARENT/GUARDIAN (required)

Print name:	Relationship to Child:
X	Date:

Special Instructions:

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