Emergency Care Plan for Child with Severe Allergies

Child's Name	Date of Birth
Allergic to	

Signs of an allergic reaction include:

Systems	Symptoms
Mouth	itching and swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	"weak" pulse, passing-out

The severity of symptoms can quickly change.

***All above symptoms can potentially progress to a life threatening situation!**

To Be Completed By Health Care Provider

If reaction is suspected give IMMEDIATELY:

Treatment prescription #1: ______________________ Dosage: __________

For the described symptoms: ______________________

Treatment prescription #2: ______________________ Dosage: __________

For the described symptoms: ______________________

Precautions and/or possible adverse reactions: ______________________

____

Contact emergency medical services whenever epinephrine (Epi-pen) is used. (*A single dose of epinephrine wears off in 15-20 minutes*).

Other pertinent information ______________________

Please note: In the case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

Physician's signature:______________________ **Date:**__________

Emergency Phone Numbers

Parent/Guardian #1: ______________________

Name Home # Work# Other#

Parent/Guardian #2: ______________________

Name Home # Work# Other#

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: ______________________ Phone: __________

Specialist's name (if any): ______________________ Phone: __________

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Parent/Guardian's Signature: ______________________ Date: __________

To Be Completed by PB & J Day School

Where in the program will the child receive care when a reaction occurs? ______________________

____

Who will take charge of the situation? ______________________

What will the staff do if the child is in the classroom? ______________________

____

. . . . on the playground? ______________________

. . . . on a field trip? ______________________

Where will the medications needed for a reaction be kept? (*Recommend in the same room or location as the child*) ______________________

Who will call the Emergency Medical System (911)? ______________________

Who will call the parents/guardian? ______________________

Who will go with the child to the hospital and stay until the parents can assume responsibility?

____

Who will care for the other children if the caregiver must take the child away from the group?

____

Is the allergy with the child's picture prominently posted in the kitchen and the eating area? ○ YES ○ NO

Trained Child Care Providers:

1. ______________________ Room: __________
2. ______________________ Room: __________

Plan of care written in collaboration with:

Director ______________________ Date: __________

Teacher ______________________ Date: __________

Projected date of plan re-evaluation: __________