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Emergency Care Plan for Child with Severe Allergies

Child's Name: _____ Date of Birth: _____

Allergies: _____

Signs of an allergic reaction include:

Systems:	Symptoms:
Mouth	Itching & 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, loss of consciousness

The severity of symptoms can quickly change.

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

Place Child's Photo Here

TO BE COMPLETED BY HEALTHCARE 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 is used. *A single dose of epinephrine wears off in 15-20 minutes.*

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

	Name	Home #	Work #	Other
Parent/Guardian #1:				
Parent/Guardian #2:				

(see emergency form for alternate if parents are unavailable)

Primary Health Provider's Name: _____ **Emergency Phone:** _____

Please complete other side.

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TO BE COMPLETED BY CHILD CARE PROVIDER

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 for a reaction be kept? _____

...while on a field trip? _____

Who will call 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 allergic child away from the group? _____

Is the allergy **with** the child's picture prominently posted in the kitchen **and** the eating area? ○ **Yes** ○ **No**

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

Parent/Guardian Signature: _____ **Date:** _____

Trained Childcare Providers:

1. _____ Room: _____

2. _____ Room: _____

Plan of care reviewed by:

Director: _____ **Date:** _____

Teacher: _____ **Date:** _____

Child Care Health Consultant: _____ **Date:** _____

Projected date of plan of re-evaluation (every six months or sooner if needed): **Date:** _____

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