ECC Emergency Care Plan for Child with Severe Allergies

Child's Name_____ **Birthdate** _____

Allergies _____

Specific Triggers (ex: eating, touching, breathing (inhalation), bug bite or other) _____

_____

_____

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 & 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:_____ Dosage: _____

For the described symptoms: _____

Treatment prescription:_____ Dosage: _____

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: _____

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EMERGENCY PHONE NUMBERS:

Parent/Guardian #1 _____

Cell #_____ Work #_____ Other _____

Parent/Guardian #2 _____

Cell #_____ Work #_____ Other _____

Primary Health Provider's Name _____

Health Provider's Emergency Phone #_____

TO BE COMPLETED BY CHILD CARE PROVIDER

What techniques will be used to avoid the exposure?_____

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: _____

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TRAINED CHILD CARE PROVIDERS:

1._____ Room: _____

2._____ Room: _____

3._____ Room: _____

4._____ Room: _____

5._____ Room: _____

6._____ 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): _____