Sunny Faces Day Care, 30 Harefield Drive, Etobicoke ON, M9W 4C9 **(416 744 0778)**

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

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

Photo of Child (recommended)

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:

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)*
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)*	

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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 home child care premises 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

HEALTHCARE PROFESSIONAL CONTACT INFORMATION: (optional)

Contact Name	Primary Contact Number

SIGNATURE OF HEALTHCARE PROFESSIONAL (optional)

X	Date:

SIGNATURE OF PARENT/GUARDIAN (required)

Print name:	Relationship to Child:
X	Date:

SUPERVISOR SIGNATURE _____ DATE: _____