Non-Food Allergy and Anaphylaxis Emergency Plan (Insect Stings, etc.)

Room # _____

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No

Attach child's photo

These forms must be updated by the child's physician every 6 months.

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or **give epinephrine**.

Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child.**

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis".)

MEDICATION/DOSES

EPINEPHRINE

- ☐ Auvi-Q
- ☐ EpiPen
- ☐ Generic Epinephrine Injection
- ☐ AdrenaClick (Impax)

Epinephrine Dose:
☐ **0.15mg IM** ☐ **0.30mg IM**

ANTIHISTAMINE

☐ Benadryl/Generic

Antihistamine Dose:
_____ **ml**

We must have 2 Epinephrine Pens on-site.

Other (e.g., inhaler, brochodilator if wheezing:

_____

_____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (_ __) _____-_____

Parent/Guardian: _____ Phone: (_ __) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (__ _) _____-_____

Name/Relationship: _____ Phone: (_ __) _____-_____

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

Calvary
Child Development Center

Medical Authorization

CCDC MEDICATION/CARE AUTHORIZATION AND RELEASE

Child's Name: _____ Age: ___ _____

☐ *For children with Food or Non-Food allergies, please check.* I acknowledge that Calvary Church ("Calvary"), including Calvary Child Development Center ("CCDC"), not an allergen-free facility, that CCDC cannot guarantee my child will not be exposed notwithstanding awareness of his/her allergies, and he/she may be exposed to an allergen while on-site at CCDC.

For All Medical Action Plans (Food Allergy, Non-Food Allergy, Seizure, or Asthma)
I hereby give permission for my child, while present at CCDC, to receive medication in accordance with the Medical Action Plan for my child or as otherwise indicated below, as prescribed by a licensed physician. I hereby authorize CCDC, including its directors, staff and volunteers, to administer mediation and to provide or arrange for medical care in accordance with the Medical Action Plan or as indicated below.

For myself and for my child, I release and discharge CCDC, Calvary, its officers, elders, employees, volunteers or other agents from all claims and liability for any loss or injury that may occur in the future as a result of exposure to allergens and any medications or care provided under this authorization and release. I further agree to reimburse, indemnify and hold Calvary and CCDC harmless from any and all costs, claims and liabilities associated with providing or arranging medical care for my child.

Parent/Guardian: _____ Signature:_____ Date: _____

Address: _____ Phone_____

Medical Need	Medication	Method of Application	Dosage	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____