



INDIVIDUALIZED ANAPHYLACTIC PLAN

This form must be completed for a child who has one or more acute or chronic** medical conditions such that he or she requires additional supports, accommodation, or assistance.*

Child's Full Name:

Child's Date of Birth:

Photo of Child (Recommended)

Date Individualized Plan Completed:

List of Allergen(s):

Epinephrine Auto-Injector Brand Name:

Epinephrine Auto-Injector Expiry Date:

Dosage:

Prevention and Supports

STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING AN ANAPHYLACTIC REACTION(S): *[Include how to prevent an allergic reaction/other medical emergency; how not to aggravate the medical condition (e.g. Pureeing food to minimize choking)]*

LIST OF MEDICAL DEVICES AND HOW TO USE THEM (if applicable): *(e.g. feeding tube, stoma, glucose monitor, etc.; or not applicable (N/A))*

LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S) (if applicable): *(e.g. glucose monitor is stored on the second shelf in the program room storage closet; or not applicable (N/A))*

SUPPORTS AVAILABLE TO THE CHILD (if applicable): *(e.g. nurse or trained staff to assist with feeding and/or disposing and changing of stoma bag; or not applicable (N/A))*

Symptoms and Emergency Procedures

SIGNS AND SYMPTOMS OF AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY: *[include observable physical reactions that indicate the child may need support or assistance (e.g. hives, shortness of breath, bleeding, foaming at the mouth)]*



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PROCEDURE TO FOLLOW IF CHILD HAS AN ALLERGIC REACTION OR OTHER MEDICAL EMERGENCY: *[Include steps (e.g. Administer 2 puffs of corticosteroids; wait and observe the child's condition; contact emergency services/parent or guardian, parent/guardian/emergency contact information; etc.)]*

PROCEDURES TO FOLLOW DURING AN EVACUATION: *(e.g. ice packs for medication and items that require refrigeration; how to assist the child to evacuate)*

PROCEDURES TO FOLLOW DURING FIELD TRIPS: *(e.g. how to plan for off-site excursion; how to assist and care for the child during a field trip)*



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Additional Information Related to the Medical Condition (if applicable):

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X This plan has been created in consultation with the child's parent / guardian.

Parent/Guardian Signature:

Print name:	Relationship to child:
Signature:	Date: (dd/mm/yyyy)

The following individuals participated in the development of this individual plan (optional):

First and Last Name	Position/Role	Signature

Emergency Contact Information

	C	W
	C	W
	C	W

TRAINING and CONSENT

I _____ (parent/guardian) hereby confirm that:

- (a) I have trained _____ (SCC Staff/Executive Director) on my child's Individualized Plan for a Child with an Anaphylactic Allergy on _____(date), and
- (b) I give consent to _____ (SCC Staff/Executive Director) to train the staff, students and volunteers at SCC who may be interacting with my child to perform the procedures detailed in my child's Individualized Plan for a Child with an Anaphylactic Allergy.

Parent/Guardian's Full Name: _____

Parent/Guardian's Signature: _____

Date(yyyy/mm/dd): _____



INDIVIDUALIZED ANAPHYLAXIS PLAN