



INDIVIDUAL ACTION PLAN - ANAPHYLAXIS

For Individuals with Special Medical Conditions and Allergies

(For example: asthma, seizures, diabetes, drug allergies, food and/or other allergies)

CHILD'S NAME: _____

INFORMATION ON MEDICAL CONDITION

Medical Condition (e.g. allergy, diabetes, etc): _____

Symptoms (e.g. rash, seizures, etc): _____

Length of time symptoms usually last: _____

Triggers (e.g. food, smell, dust, excitement, exercise, etc): _____

Usual treatment (e.g. medication, rest, etc): _____

How does child usually react, and what helps comfort your child: _____

Please note any other related information:

ACTION PLAN

Describe symptoms e.g. difficulty breathing, temperature etc. In the event that:

occurs your Caregiver will (please number all boxes below that apply in order of priority with all boxes being numbered):

- Call 911
- Call parent/guardian
Parent/Guardian's name: _____
Work phone: _____ Home phone: _____
Cell phone: _____ Other phone: _____
- Call child's doctor
Doctor's name: _____ Doctor Phone: _____

PLEASE TURN OVER ⇒

- Administer the following medication (please note medical policies apply)
 Name of medication: _____
 Dosage: _____
 Instructions: _____

- Other (please specify): _____

This form will be kept in the child's file. A copy will be posted with the allergy list in the Child's Play area, and a copy attached to his/her emergency cards kept in the Caregivers file and in the office.

I, (undersigned) have filled out the above information as accurate as possible to my knowledge. I understand that the Caregiver and staff of Caring For Kids will follow the above instructions to the best of their ability. I understand that this form will need to be filled out and resigned annually or if any changes occur to the above information prior to resigning date. I understand that it is my responsibility to notify the Caregiver if any changes need to be made.

I, (undersigned) give permission for my Caregiver _____ and /or Caring For Kids staff/designate to follow the above action plan as laid out by me in the event that they suspect that the above mentioned child is experiencing a reaction as per the outlined symptoms. I give my Caregiver _____ or Caring For Kids staff/designate permission to administer the above-mentioned medication as per the indicated directions and dosage outlined in the action plan.

I understand that the Caregiver will undergo training specific to my child's condition on the procedures to be followed in the event that my child has an anaphylactic reaction, including how to recognize the signs and symptoms of anaphylaxis and administer medication.

The following individual will provide the training:

Parent/guardian or child's physician: _____

Phone: _____ Date and time of training: _____

I understand that this training MUST be received PRIOR to my child starting care.

PARENT/GUARDIAN'S NAME (please print): _____

PARENT/GUARDIAN SIGNATURE: _____

CAREGIVER'S SIGNATURE: _____

HOME CHILDCARE CONSULTANT SIGNATURE: _____

DATE: _____