FORM A-500

Emergency Care Plan for Child with Severe Allergies

Place Child's Picture Here

Child's Name: _____ Date of Birth: ___/___/___

Allergy to: _____

_____

Signs of an allergic reaction include:

Systems:	Symptoms:
• Mouth	itching and swelling of the lips, tongue, or mouth
• Throat*	itching and/or a sense of tightness in the throat, hoarseness and 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, "passing-out"

The severity of symptoms can quickly change.

*** All above symptoms can potentially progress to a life threatening situation!**

TO BE COMPLETED BY HEALTH CARE PROVIDER

If reaction is suspected give IMMEDIATELY:

Treatment prescription #1: _____ Dosage: _____

For the described symptoms: _____

Treatment prescription #2: _____ Dosage: _____

For the described symptoms: _____

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)

Other pertinent information: _____

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: ___/___/___

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____

Name Home # Work # Other #

Parent/Guardian #2: _____

Name Home # Work # Other #

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: _____ emergency phone: _____

Specialist's name (if any): _____ emergency phone: _____

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional medical information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Parent/Guardian's signature: _____ Date: ___/___/___

- Over -

TO BE COMPLETED BY CHILD CARE PROVIDER

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 needed for a reaction be kept? (Recommend in the same room or location as the child) _____

.....while on a field trip? _____

Who will call the Emergency Medical System (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

TRAINED CHILD CARE PROVIDERS:

1. _____ Room: _____

2. _____ Room: _____

Plan of care written in collaboration with:

Director: _____ Date: ___/___/___

Teacher: _____ Date: ___/___/___

Child Care Health Consultant: _____ Date: ___/___/___

Projected date of plan re-evaluation: Date: ___/___/___