ANAPHYLAXIS ALLERGY
INDIVIDUAL ACTION PLAN & EMERGENCY PROCEDURE

Child's Name (Please Print):_____

Allergy:_____

Signs/Symptoms:_____
_____
_____

Please note any other related information, such as usual treatment, length of time symptoms typically last, how the child typically reacts and what helps to comfort the child:

MONITORING & AVOIDANCE STRATEGIES:

ACTION PLAN In the event that: (symptoms Occur)

The child care staff will: (Please number the boxes below in order of priority)

☐ Administer the Following Medication – Name of Medication:
_____

Dosage: _____ Instructions:
_____

☐ Call 911

☐ Call Parent/Guardian – Parent/Guardian's Name:
_____

Home Phone: _____Work Phone: _____ Cell Phone:_____

2nd Parent/Guardian's
Name:_____

Home Phone _____Work Phone: _____Cell Phone: _____

☐ Call the Child's Doctor – Doctor's Name _____
Phone _____

☐ Other (please specify): _____

This signature is your permission for the center to administer the self-administering medication, in the event of a severe anaphylactic reaction.

Parent/Guardian's Name (please Print): _____

Parent/Guardian's Signature: _____

Date Signed**:**_____

I have reviewed this plan (Teaching Staff):
_____
_____
_____
_____
_____
_____