Child Care Emergency Plan for Allergic Reactions

ALLERGY TO: ____________________________________________________________

Student’s Name: ___________________________________________ D.O.B: ____________________________

Asthma Yes* ☐ No ☐ *High Risk for severe reaction

SIGN OF AN ALLERGIC REACTION:

<table>
<thead>
<tr>
<th>Systems</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOUTH</td>
<td>itching &amp; swelling of the lips, tongue, or mouth</td>
</tr>
<tr>
<td>THROAT</td>
<td>itching and/or a sense of tightness in the throat, hoarseness and hacking cough</td>
</tr>
<tr>
<td>SKIN</td>
<td>hives, itchy rash, and/or swelling about the face or extremities</td>
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<tr>
<td>GUT</td>
<td>nausea, abdominal cramps, vomiting, and/or diarrhea</td>
</tr>
<tr>
<td>LUNG</td>
<td>shortness of breath, repetitive coughing, and/or wheezing</td>
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<tr>
<td>HEART</td>
<td>“thready” pulse, “passing-out”</td>
</tr>
</tbody>
</table>

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Action for minor reaction:

If symptom(s) are: ____________________________________________________________

☐ Administer: ____________________________________________ medication/dose/route

☐ Then call: Parent/Guardian and Health Care Provider

☐ If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

Action for severe reaction:

If symptom(s) are: ____________________________________________________________

☐ Administer: ____________________________________________ medication/dose/route IMMEDIATELY!

☐ Call: 911 (Never hesitate to call 911)

☐ Call: Parent or Guardian

☐ Call: Health Care Provider

Parent/guardian name____________________________________________________ phone # __________________

Parent/guardian signature________________________________________ Date: ________________

Health Care Provider name________________________________________

Health Care Provider signature (Required) _____________________________

Child Care Health Program, Public Health - Seattle & King County 03/2007
Emergency Contacts

1. ____________________________
   Relation: __________ Phone __________
2. ____________________________
   Relation: __________ Phone __________
3. ____________________________
   Relation: __________ Phone __________

Trained Staff Members

1. __________ Room ______
2. __________ Room ______
3. __________ Room ______

EPIPEN® and EPIPEN® Jr. Directions

1. Pull off gray activation cap.

![EPIPEN](image1)

2. Hold black tip near outer thigh (always apply to thigh).

![EPIPEN Jr.](image2)

3. Place firmly against thigh and press until Auto-injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.