

**Polka Dot Parent Handbook**

**ANAPHYLAXIS INDIVIDUAL ACTION PLAN**

CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MY CHILD’S ANAPHYLAXIS TRIGGERS ARE: (Tick all that apply)

Peanuts \_\_\_\_\_ Nuts (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milk\_\_\_\_ All Dairy \_\_\_\_\_ Eggs \_\_\_\_\_\_\_ Shellfish \_\_\_\_\_\_\_ Fish\_\_\_\_\_\_\_

Food Additives \_\_\_\_\_ (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insect Stings \_\_\_\_\_ (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_ (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others \_\_\_\_\_ (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MY CHILD’S ANAPHYLAXIS SYMPTOMS USUALLY ARE:

\_\_\_ swelling (eyes, lips, face, tongue) \_\_\_ difficulty breathing or swallowing

\_\_\_ Cold, clammy, sweaty skin \_\_\_ flushed face or body

\_\_\_ fainting or loss of consciousness \_\_\_ vomiting

\_\_\_ coughing or choking \_\_\_ stomach cramps, diarrhea

\_\_\_ Dizziness, confusion \_\_\_ change of voice, hoarseness

\_\_\_ Other (be specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MY CHILD’S EMERGENCY TREATMENT IS:

\_\_\_ Epi-Pen Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Epi-Pen Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROCEDURE TO FOLLOW IN AN EMERGENCY SITUATION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the Director, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to conduct

(Parent’s Name)

subsequent training when needed to new staff and volunteers regarding my child’s Action Plan and Administering of the Epi-Pen.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENTS’ AVOIDANCE STRATEGIES

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PARENTS’ EMERGENCY CONTACT INFORMATION

|  |  |  |
| --- | --- | --- |
| PARENT’S NAME | MOTHER | FATHER |
| HOME NUMBER |  |  |
| CELL NUMBER |  |  |
| WORK NUMBER |  |  |
| ALTERNATE NUMBER |  |  |

I understand that by completing this form:

* I am giving Polka Dot Preschool staff the authorization to administer the Epi-Pen to my child if required.
* The staff at Polka Dot Preschool will call 911 immediately if my child is having an Anaphylactic Allergic Reaction.
* That Polka Dot Preschool will follow the necessary procedures whether myself or the emergency contacts can be reached or not.
* Parents are responsible for informing Polka Dot Preschool if there are any changed required to this form.
* Polka Dot Preschool will require this form to be reviewed annually with parents.

\*\*\*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have trained the staff below, on my child’s Individual

(Parent’s Name)

Anaphylaxis Action Plan and Administering of the Epi-Pen.

|  |  |
| --- | --- |
| Staff Name | Date of Training |
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