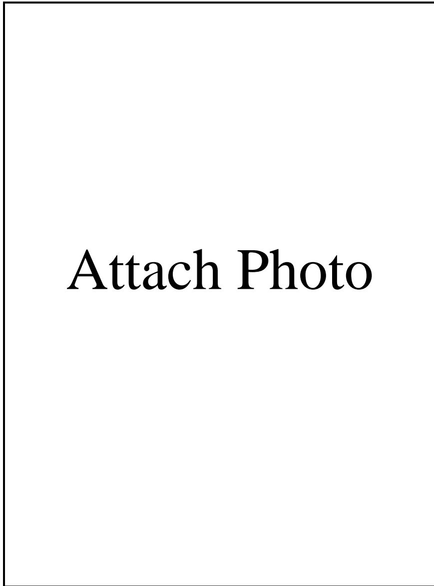
AURORA CHILDREN'S CENTRE
ANAPHYLAXIS EMERGENCY PLAN



Child's Name: ______________________________ Room ____________

Life Threatening Allergy to: ______________________________________

Epinephrine Auto Injector (Epi-Pen) Location: **Classroom Binder**

________________ has demonstrated to staff, student, and volunteers
Parents Name how to administer the Epinephrine Auto Injector.

Parent's Signature: ____________________________ Date: ___________

________________________ gives consent to _______________________
Parent Name Supervisor/Designate
to train those not able to attend the training by the parent or physician.

Parent Signature ___________________________________

Signs/Symptoms of Allergic Reaction and Anaphylaxis: **Expiry Date ________________**

- **Skin system**: hives, swelling, itching, warmth, redness, rash
- **Respiratory system (breathing):** coughing, wheezing, shortness of breath, chest pain/tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing
- **Gastrointestinal system (stomach):** nausea, pain/cramps, vomiting, diarrhea
- **Cardiovascular system (heart):** pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock
- **Other:** anxiety, feeling of "impending doom", headache, uterine cramps, metallic taste

Early recognition of symptoms and immediate treatment could save a person's life.

Act Quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. **Give epinephrine auto-injector** (EpiPen) at the first sign of a known or suspected anaphylactic reaction.
2. **Call 9-1-1.** Tell them someone is having a life-threatening allergic reaction.
3. **Give a second dose of epinephrine** in 5 to 15 minutes IF the reaction continues or worsens.
4. **Go to nearest hospital immediately,** even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician.
5. **Call emergency contact person. (e.g. parent/guardian)**

EMERGENCY CONTACT INFORMATION:

Name	Relationship	Home Phone	Work Phone	Cell Phone

The undersigned patient, parent, or guardian authorizes any adult to administer epinephrine in the event of an anaphylactic reaction, as described above.

_______________________________ _______________________
Patient/Parent/Guardian Date

_______________________________ _______________________
Physician Signature Date

____
Physician's Address

____
Physician's phone number

Physician Stamp

(REVISED August 2024)