

# ANAPHYLAXIS CARE PLAN

Centre:  FFOSC  
 MJOSC

Date: \_\_\_\_\_

Child's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Medical number: \_\_\_\_\_

Allergies: \_\_\_\_\_

## Signs & Symptoms of an allergic/anaphylaxis response in child:

- Skin rashes, itching, hives
- Shortness of breath, wheezing
- Cold/clammy skin
- Voice changes
- Dizziness, fainting
- Stomach pain
- Vomiting
- Diarrhea

Other signs & symptoms:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- I have provided an Epi-Pen to OSC for emergency situations.
- I have taped a photo of my child to the outside of the Epi-Pen's case.
- I authorize the OSC staff to administer the Epi-Pen to my child in case of emergency.

When to administer the Epi-Pen: \_\_\_\_\_

\_\_\_\_\_

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Who to call in an emergency situation:

Name	Relationship to child	Phone number(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____