CCEP Emergency Plan for Child with Severe Allergies

Child's Name: ____ Date of Birth: ______/______/______

Allergy to ____

Signs of an allergic reaction include but are not limited to:

Systems:	Symptoms:
• Mouth	Itching and swelling of the lips, tongue, or mouth
• Throat*	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• Skin	Hives, itchy rash, and/or swelling about the face or extremities
• Gut	Nausea, abdominal cramps, vomiting, and/or wheezing
• Lung*	Shortness of breath, repetitive coughing, and or/ wheezing
• Heart*	"Weak" pulse, "passing-out"

The severity of symptoms can quickly change.

***All above symptoms can potentially progress to a life threatening situation!**

TO BE COMLETED BY HEALTH CARE PROVIDER

If reaction is suspected give IMMEDIATELY:

Treatment prescription #1: ____ Dosage: ______________________

For the described symptoms: ____

Treatment prescription #2: ____ Dosage: ______________________

For the described symptoms: ____________________________________ Dosage: ______________________

Precautions and/or possible adverse reactions:____

Contact emergency medical services whenever epinephrine "Epi-Pen" is used.

(A single dose of epinephrine wears off in 15-20 minutes)

Other pertinent information:____

Physician's signature: ____________________________**Physician's Phone:**____________________Date:___________

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: ____

Name Home# Work# Cell#

Parent/Guardian #2: ____

Name Home# Work# Cell#

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: ________________________________ Emergency Phone:__________________

Specialist's name (if any): ____ Emergency Phone: __________________

I give my permission for Christ Church Episcopal, Christ Church Episcopal Preschool, and their employees and agents, to follow this plan of care prescribed by the physician. I also give my permission for CCEP to call the health care provider(s) listed above for any additional medical information about my child. I agree that CCEP may disclose any health related information about my child to any health care provider(s) as deemed by CCEP as necessary for the medical care of my child. I understand that CCEP is not a health care provider and is acting as the parent/guardian's agent. Parent/guardian agrees to indemnify and hold harmless Christ Church Episcopal, Christ Church Episcopal Preschool, and their directors, officers, employees, and agents from any claim, cause of action, and/or damages related to the determination to administer, and/or the administration of the prescribed medication to the above-listed child.

Parent/Guardian Signature: ____Date: ______/______/______

Revised 8-2015