Individualized Plan of Care for Child with Epi-Pen

Child's Name: _____ Date of Birth _____

Child's Address: _____ Phone #: _____

Physician's Name: _____ Physician's Phone #: _____

Physician's Address: _____

Asthma: ❑ Yes ❑ No Allergy to: _____

Procedures for Emergency Treatment (Check One)

❑ Administer medication before symptoms occur if patient ingests or thinks he/she has ingested the above named food (if bee sting allergy-if stung).

❑ Observe patient for symptoms and administer medication if symptoms occur (circle symptoms below).

Medication to be Administered: (number in order to be followed <u>and</u> circle appropriate medicine)

Order	
	Administer Epi-Pen Jr. **or** Epi-Pen Sr.
	Administer second Epi-Pen 10-20 minutes after first dose
	Administer Benadryl _____ Tsp. **or** Atarax ____ Tsp. Swish and Swallow
	Other:
	Transport to ER (Call 911)
	Contact Parents

IF FOOD ALLERGY, PLEASE INDICATE LEVEL OF CONTACT WHICH MAY CAUSE A REACTION:

❑ Ingestion ❑ Touch ❑ Airborne

SYMPTOMS OF ANAPHYLAXIS (**circle <u>all</u> those which apply to this child**):

Chest tightness, **C**ough, **S**hortness of breath, **W**heezing, **H**ives or swelling, **T**ightness in throat, **D**ifficulty swallowing, **H**oarseness, **D**izziness or faintness, **S**welling of lips tongue or throat, **I**tchy mouth, **I**tchy skin, **S**tomach cramps, **V**omiting, or **D**iarrhea

Physician's Signature: _____ Date: _____

I give permission to the Boys & Girls Club and Family Center of Bristol's child care personnel to administer the above medication as indicated to my child.

Parent's Signature: _____ Date: _____

I have reviewed the care plan for this child and understand what steps I will follow in case of an emergency.

Child Care Teachers Signatures: _____