

MUNICIPALITY OF SOUTH BRUCE Section A: Anaphylaxis Emergency Care Plan

This form must be completed upon registration, whenever there is a change in symptoms or medication given. Participant Name: ______DOB:_____ Address: ______ Postal Code: _____ Current photo here Telephone: Life threatening Allergy to: **SEVERE SYMPTOMS MILD Symptoms** NOSE- Itchy or runny nose, sneezing LUNG- Shortness of breath, wheezing, repetitive Mouth- Itchy mouth SKIN- A few hives, mild itch HEART- Pale or blush skin, faintness, weak STOMACH- Mild nausea or discomfort pulse, dizziness THROAT- Tight or hoarse throat, trouble FOR MILD SYMPTOMS FROM MORE THAN ONE breathing or swallowing MOUTH- Significant swelling of the tongue or lips SYSTEM AREA, GIVE EPINEPHRINE SKIN- Many hives over body, widespread FOR MILD SYMPTOMS FROM A SINGLE **SYSTEM** AREA, FOLLOW THE DIRECTIONS STOMACH- Repetitive vomiting, severe diarrhea, OTHER- Feeling something bad is about to BELOW: 1. Antihistamines may be given, if ordered by happen, anxiety, confusion a healthcare provider. Or a combination of symptoms from different 2. Stay with the person, alert emergency body areas 1. INJECT EPINEPHRINE IMMEDIATELY contacts 3. Watch closely for changes. If symptoms worsen, give epinephrine. 2. Call 911. •Lay the person flat, raise legs and keep warm. If MEDICATION/DOSES breathing is difficult or they are vomiting, let them sit up Epinephrine Brand or Generic: _____ or lie on their side. • If symptoms do not improve, or symptoms return, Epinephrine Dose: ____ mg IM more doses of epinephrine can be given about 5 minutes or more after the last dose. Antihistamine Brand or Generic: • Alert emergency contacts and supervisor • Patient should be transported to the ER, even if Antihistamine Dose: symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return. Other (eg inhaler, if wheezing): _____ Prevention Tips: Epi-Pen® Location:

Epi-Pen® Expiry Date:



Section B: Parent/Guardian Informed Authorization and Release for the Administration of an Epi-Pen ${\Bbb R}$ or Medication

I/We have hereby authorized that an Epi- administered in the event of an Anaphylax	Pen® and/or medication listed in Section A to be xis emergency
I/We understand that this service will be previously.	provided by a person without medical or nursing
whenever there is a change in the physicia	South Bruce with a written updated medical statement an's instructions with respect to medication. It is staff informed is my responsibility. I/We agree that n their person.
I/We agree it is my responsibility to ensur name and name of the drug, and to ensur	re the medication is properly labeled with the child's re that the drug is not expired
	ecreation Services programs, facilities, staff or support romise a risk free or allergen free environment for my
Epi-Pen® injection, and I hereby release, administrator, Municipality of South Bruce	cient authority to administer the medication through indemnify and shall not hold the medication e, Facilities and Recreation Department or any of its r which may arise out of the said medication r at any given time in future.
Please initial each paragraph in Secti	ion B
Signature for Sections A and B	
Parent/Guardian's Signature	Date
Parent/Guardian's Signature	Date
Staff Signature	 Date