



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:

- Mouth
- Throat*
- Skin
- Gut
- Lung*
- Heart*

Symptoms:

Itching and swelling of the lips, tongue, or mouth
 Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
 Hives, itchy rash, and/or swelling about the face or extremities
 Nausea, abdominal cramps, vomiting, and/or wheezing
 Shortness of breath, repetitive coughing, and or/ wheezing
 "Weak" pulse, "passing-out"

The severity of symptoms can quickly change.

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

TO BE COMPLETED 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#
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Parent/Guardian #2: _____

Name	Home#	Work#	Cell#
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(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: ____/____/____