CONFIDENTIAL

INDIVIDUALIZED ANAPHYLACTIC PLAN (IAP)

Individualized Anaphylactic Plan (IAP)

Child's Full Name: _____

Child's Date of Birth: _____ /_____ /_____
(dd) (mm) (yyyy)

Child's Program/Room: _____

Date Individualized Plan Completed: _____

Photo of Child

List of Allergen(s)/Causative Agent(s):

- _____
- _____

Asthma: ☐ Yes (higher risk of severe reaction) ☐ No

Location of medication storage: _____

Epinephrine Auto-Injector Brand Name: _____

Epinephrine Auto-Injector Expiry Date: _____ /_____ /_____
(dd) (mm) (yyyy)

Other Emergency Medications [1]: _____

Emergency Services Contact Number: **911**

Preventions and Supports

Child's specific signs and symptoms of a non-life-threatening allergic reaction:	Child's specific signs and symptoms of a life-threatening anaphylactic reaction:
Description of the procedure to follow if child has a non-life-threatening allergic reaction:	Description of the procedure to follow if child has a life-threatening anaphylactic reaction:
Steps to reduce risk of exposure to causative agent(s)/allergen(s):	
Additional notes (if applicable):	

Emergency Procedures to Follow

Procedures to follow if the child has an anaphylactic reaction or other emergency:
Procedures to follow during an evacuation:
Procedures to follow during a field trip:

Additional Information Related to the Anaphylactic Condition (if applicable):

Parental Statement

I, _____ (parent/guardian name), hereby give consent for my child named on Page 1 to do the following checked items:

My child will: *(check all that apply)*

- ☐ Carry their emergency allergy medication in a designated location as specified below:

  Location *(e.g. blue fanny pack around waist)*: _____
- ☐ Self-Administer their own medication in the event of an anaphylactic reaction

AND/OR

I, _____ (parent/guardian name), hereby give consent to any person with training on this plan to administer my child's epinephrine auto-injector and/or asthma medication and to follow the procedures set out in my child's Individualized Anaphylaxis Plan.

Parent/Guardian Initials: _____

Emergency Contact Information

Contact Name	Relationship to Child	Primary Contact Number	Secondary Contact Number

Healthcare Professional Contact Information (optional)

Contact Name	Profession (i.e. Family Doctor, etc.)	Primary Contact Number

Signature of Healthcare Professional (optional)

X	Date:

Signature of Parent/Guardian (required)

Print Name:	Relationship to Child:
X	Date:

Individualized Plan Review Period

This Individualized Anaphylactic Plan will be reviewed with the child's parent/guardian at least annually or as information needs to be updated. [2]

Special Instructions

[1] Please complete an Authorization for Prescription Medication form for all medications other than epinephrine auto-injectors.
[2] Each child with an anaphylactic allergy requires their own individualized plan. If significant changes and updates are required, a new individualized plan must be completed.
[3] Children's personal health information must be kept confidential.

To be completed by all YMCA Child Care Staff, Placement Students & Volunteers

Child's Name: _____

The YMCA of Northeastern Ontario's Child Care Procedure for Children with Anaphylaxis must be reviewed with a signed acknowledgement upon commencement of employment, student placement or volunteer role with the YMCA and annually thereafter. In addition, after any revision of this form, it will be reviewed by all child care staff, placement students and volunteers.

By signing below, I acknowledge that I have been trained on how to treat the above-named child in the event of an anaphylactic emergency and that I fully understand and agree to abide by the **YMCA of Northeastern Ontario's Child Care Procedure for Children with Anaphylaxis and this Child's Individualized Anaphylactic Plan.**

Should I have any questions or concerns regarding any YMCA Policy or Procedures, I may contact my YMCA Child Care Supervisor or refer to our Child Care Legislation & Procedures Manual.

Acknowledgement Record of all Child Care Staff, Placement Students or Volunteers

Date	Staff, Placement Student or Volunteer's Full Name	Signature

**** This original will be kept in the child's file with a copy to be posted in all program areas (anywhere the child may attend) with a cover page for confidentiality and attached to the educators' clipboard.***

Dispensing Record – To be completed by Child Care Staff

Child's Name: _____

Medication: ☐ Epi-Pen ☐ Puffer Other: _____

As a best practice, to ensure that the correct dosage is given, **it is highly recommended (where possible) to have another educator colleague or Supervisor verify your medication measurement and cross reference the amount with the actual prescription bottle or doctor's note.** The second staff (Staff 2) will initial next to the staff lead (Staff 1) who is administering the medication.

Date	Time	Dosage Given & Additional Notes	Staff 1 Initials	Staff 2 Initials

When the above dispensing record form is full, please begin a new one and attach the forms (if the medication is being continued). Please sign and date the below before switching to a new form or once the medication is completed.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____