JINGBAO™ BILINGUAL

Individual Allergy Action Plan

Child's Name:____________________________ Date of birth:_____________________

Home Address:___________________________ Home Phone:___________________

Action Plan and Procedure (to be completed by the parent/guardian)

Child Care Staff Roles and Responsibilities

Adhere to JINGBAO™ Anaphylactic Policy

- Conduct a check to confirm that the child has the required medication with him/her before each transition. (ie, from classroom to outdoor/gym, leaving school, etc.)
- Administer medication following the instructions set out in the child's **Allergy Action Plan**
- Remain calm in the situation of emergency.
- Debrief after the emergency.
- Complete written report when dealing with the emergency.
- File **Serious Occurrence** report if the child's reaction is life-threatening.

Parent Agreement

- I, ______________________, acknowledge that I have participated in the development of this **Allergy Action Plan** and agree to undertake the parent's responsibilities listed here.
- I give my consent for the staff of JINGBAO™ to execute the child care commitment as outlined here.
- In the event of an emergency, I authorize JINGBAO™ staff to administer the designated medication (Appendix A) and obtain medical assistance for my child.
- If my child has severe allergic reaction that involves breathing and/or circulation (**Anaphylaxis**), I agree to provide an EPI-PEN and a staff training before my child starts **(Appendix B & C)**
- I agree to assume responsibilities for all costs associated with the medical assistance and absolve JINGBAO™ and its employees of any responsibility for any adverse reaction resulting from administration of the medication for my child.

Parent/Guardian's Signature:_________________________ **Date:**______________________

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Appendix A

Authorization for Medication Administration Form

Child's Name:_________________________ **Date of Birth:**_______________________

I, ____________________________________, authorize JINGBAO™ (______________________)

Printed Name of Parent/Guardian Name of the site

and its employees to administer the medication listed below to my child.

Signature of Parent / Guardian: **Date:**

Medication Information
This medication is to be given on the judgment of JINGBAO™ and its designated staff based on the needs of the child. This form **must** be completed by the parent/guardian for administration of any emergency medications. Information should pertain to only one medication per form. The record will be retained in the child's file. Name of Medication: ___________________Date of Purchase: ________Date of Expiry: ________ Storage Requirement: ____ Description(Please select): - Liquid - Inhalant -Other:______________ Reason for administration of medication: ____ Start Date: ____________________________ End Date: ____________________________ Dosage: _____________________ At: ___________________ (Time(s) of administration) Side Effects: ____ Stop medication if the following reaction is observed: _____________________________________

Important: When a child requires emergency/special circumstance medication, a parent must be notified as soon as possible.

Administration Record (to be completed by JINGBAO staff)

Date Given	Time Given	Amount Given	ECE Admin.	ECE Comments/observations

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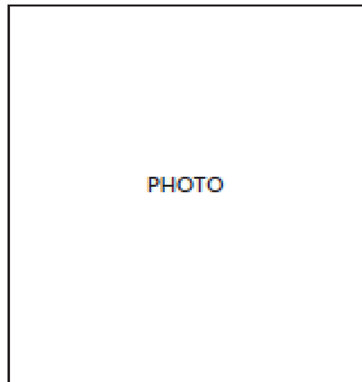
Anaphylaxis Emergency Plan: ______________________________ *(name)*

This person has a potentially life-threatening allergy (anaphylaxis) to:



(Check the appropriate boxes.)

- ☐ Peanut
- ☐ Tree nuts
- ☐ Egg
- ☐ Milk
- ☐ Other: ______________________________
- ☐ Insect stings
- ☐ Latex
- ☐ Medication: ______________________________

Food: The key to preventing an anaphylactic emergency is absolute avoidance of the allergen. People with food allergies should not share food or eat unmarked / bulk foods or products with a *"may contain"* warning.

Epinephrine Auto-Injector: Expiry Date: ______________ / ______________

Dosage: ☐ EpiPen® Jr 0.15 mg ☐ EpiPen® 0.30 mg
☐ Twinject™ 0.15 mg ☐ Twinject™ 0.30 mg

Location of Auto-Injector(s): ______________________________

☐ **Asthmatic:** Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

A person having an anaphylactic reaction might have ANY of these signs and symptoms:

- **Skin:** hives, swelling, itching, warmth, redness, rash
- **Respiratory (breathing):** wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing
- **Gastrointestinal (stomach):** nausea, pain/cramps, vomiting, diarrhea
- **Cardiovascular (heart):** pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock
- **Other:** anxiety, feeling of "impending doom", headache

Early recognition of symptoms and immediate treatment could save a person's life.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. **Give epinephrine auto-injector** (e.g. EpiPen® or Twinject™) at the first sign of a reaction occurring in conjunction with a known or suspected contact with allergen. Give a second dose in 10 to 15 minutes or sooner **IF** the reaction continues or worsens. (See second page for instructions.)
2. **Call 911.** Tell them someone is having a life-threatening allergic reaction. Ask them to send an ambulance immediately.
3. **Go to the nearest hospital**, even if symptoms are mild or have stopped. Stay in the hospital for an appropriate period of observation, generally 4 hours, but at the discretion of the ER physician. The reaction could come back.
4. **Call contact person.**

Emergency Contact Information

Name	Relationship	Home Phone	Work Phone	Cell Phone

The undersigned patient, parent, or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

Patient/Parent/Guardian Signature	Date	Physician Signature	Date

Appendix B

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Appendix C

Individual Anaphylactic Training Record

The following part is required to be completed by the trainer (Paren/physician)
Child's Name:______________________ **Date of Birth:** _____________________
Please indicate if the trainer is a: **Parent** ________ **Physician**_________
Trainer's Signature:_______________________ **Date of Signature:** _________________

This training record signifies that you have been trained to handle anaphylactic emergency at JINGBAO™ and that you have read and understand the Anaphylactic Policy and the child's Individual Emergency Action Plan. An annual review with signature is also required.

Staff's Name	Date	Staff's signature	Witness's Name