CITY OF PORT COQUITLAM

Parks and Recreation Department

ANAPHYLAXIS ACTION PLAN

Program/Activity ____________________ **Location** _______________ **Leader** _________________________

Child's Name: ___________________________ Birthdate: _________________ Medic Alert: Yes_____ No____

Parent/Guardian: _________________________ Home #: _________________ Work#: ____________________

Emergency Contact: ______________________ Home #: _________________ Work#: ____________________

Physician: _______________________________ Office #: ____________________

MY CHILD'S ANAPHYLAXIS TRIGGERS ARE:

☐ peanuts ☐ nuts ☐ milk ☐ all dairy ☐ eggs ☐ shellfish ☐ fish

☐ food additives (List): ____

☐ insect stings (List): ____

☐ medications (List): ____

☐ others (List): ____

MY CHILD'S ANAPHYLAXIS SYMTOMS USUALLY ARE:

☐ swelling (eyes, lips, face, tongue)
☐ difficulty breathing or swallowing
☐ cold, clammy, sweaty skin
☐ flushed face or body
☐ fainting or loss of consciousness
☐ vomiting
☐ coughing or choking
☐ stomach cramps, diarrhea
☐ dizziness, confusion
☐ change of voice
☐ others (List): ____

____

MY CHILD'S EMERGENCY TREATMENT IS:

Location EpiPen is kept: ____

☐ Anti-histamine (specify brand and dosage): ____

☐ EpiPen

NOTE: EpiPens must be provided.

CALL 911 AND TELL THE DISPATCHER THAT A CHILD IS HAVING A LIFE-THREATENING ANAPHYLACTIC REACTION.

CALL THE PARENT OR GUARDIAN.

Parent/Guardian Signature: __________________________________ Date completed _____________________

Staff Signature ____ Date completed _____________________