Child Care Emergency Treatment Form

Child's Name: _____ Date of Birth: _____

Child's Address: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____

Asthma: Yes ____ No ___ Allergy to: _____

Procedures for Emergency Treatment: (Check One)

_____ Administer medication before symptoms occur if patient ingests or thinks he/she has ingested the above named food (if bee sting allergy-if stung)

_____ Observe patient for symptoms and administer medication if symptoms occur (circle symptoms below)

Medication to be Administered: (**number in order to be followed** and circle appropriate medicine)

____ Administer Adrenaline: Epi-Pen Jr. Epi-Pen Sr.

____ Administer second Epi-Pen 20 minutes after the first (*There are some ambulances that do not carry an Epi-Pen, so more than 30 minutes could pass before a second Epi-Pen is accessible)

____ Administer: Benadryl _____Tsp. or Atarax _____Tsp. Swish and Swallow

____ Other: _____

____ Transport to ER (CALL 911)

____ Call Parents

IF FOOD ALLERGY, PLEASE INDICATE LEVEL OF CONTACT WHICH MAY CAUSE A REACTION:

____ Ingestion ____ Touch _____Airborne

If ASTHMA, please list **CLEARLY** circumstances under which medication is to be given or 911 called.

_____
_____
_____

SYMPTOMS OF ANAPHLAXIS: (circle all those which apply to this child)

Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue, throat
Stomach cramps, vomiting, or diarrhea
Hives or swelling
Dizziness or faintness
Itching mouth, itchy skin

Physician's Signature: _____ Date: _____

I give permission for _____ Child Care personnel to administer the above medication as indicated to my child.

Parent's Signature: _____ Date: _____