

**Eunoia Forest School**  
**Individualized Plan and Emergency Procedures**  
**for a Child with an Allergy**

\* denotes mandatory information



Child's Photo

\*Child's name:

Date of birth:

\*Date plan completed:

Emergency Services: Call **911**

\*List of **causative agent(s)**:

\***Anaphylaxis:**  Yes  No

\***Asthma:**  Yes (higher risk of severe reaction with anaphylaxis)  No

<b>Emergency Medications</b>				
<b>Name of Medication (include brand)</b>	<b>Expiry Date</b>	<b>*Location</b>	<b>*Location of Extras (N/A if no extras stored at Eunoia)</b>	<b>Disposal Instructions</b>

Does the child have **permission to carry** emergency medication?  Yes  No

\***Monitoring** strategies:

<b>Non-Life Threatening Reaction</b>	<b>Life-Threatening Reaction</b>
*Signs and symptoms (specific to the child):	*Signs and symptoms (specific to the child):
* Procedures to follow:	* Procedures to follow:
<p>*Procedures to follow in the event of any other medical emergency:</p>	
<p>* Procedures to follow during an <b>evacuation</b> (e.g., ice packs for medication that requires refrigeration, how to assist the child to evacuate):</p>	

\* Procedures to follow during **other emergencies**:

\* **Steps and Strategies to reduce risk of exposure** to causative agents (include **routine daily management strategies** and specify **who will and is authorized to perform** the strategies; specify what **accommodations** will be made, if necessary, to support the strategies and to support the child's participation in all Eunoia activities):

Any additional notes (e.g., what additional supports will be provided at Eunoia, notes and instructions from a health professional):

- Eunoia's Emergency Management and Fire Safety/Evacuation Policy and Procedures was considered as this plan was created.
- The child's preferences were considered as this plan was created.
- This plan has been created in consultation with the child's parent/guardian.
- The parent/guardian has trained at least Eunoia's Owner/Operator or Designate on the procedures to follow if the child has an anaphylactic reaction.

Date of training: \_\_\_\_\_

#### **Parental Statement**

I, \_\_\_\_\_ (parent/guardian), hereby give consent for my child, \_\_\_\_\_, to:

carry their emergency medication in the following location (e.g. blue fanny pack around their waist):\_\_\_\_\_

and/or

self-administer their own emergency medication as needed

**AND/OR**

I, \_\_\_\_\_ (parent/guardian), hereby give consent for any person with training on this plan to administer my child's emergency medication and to follow the procedures set out in this plan

**AND/OR**

I, \_\_\_\_\_ (parent/guardian), hereby give consent for my child's signs and symptoms to be shared with their peers for the purpose of helping identify when a medical incident occurs

**AND/OR**

I, \_\_\_\_\_ (parent/guardian), acknowledge that I am responsible for notifying Ellisha Blair or a staff member as soon as possible if there are changes to my child's medical needs.

**AND/OR**

I, \_\_\_\_\_ (parent/guardian), hereby give consent for this plan to be shared with:

all staff at Eunoia  all volunteers at Eunoia  
 the following members of the Eunoia team: \_\_\_\_\_

and/or

third party contractors who have direct contact with my child, if deemed necessary by Eunoia staff.

Parent/guardian initials: \_\_\_\_\_

**Communicating** about this plan (specify the **format** and **frequency** for communication between a parent/guardian, the Owner/Operator or Designate, the child, health professionals, and/or Eunoia staff. Identify **any other individuals** who should be involved in communication about the plan):

---



---

**\*Emergency Contact Information – Provide contact information for at least 2 people**

Contact Name	Relationship to Child	Primary Phone #	Additional Phone #

Signature of **health professional** (optional)

X	Date:
---	-------

\* Signature of **parent/guardian**

Print name:	Relationship to Child:
-------------	------------------------

X	Date:
---	-------

Having seen that the parent/guardian consents for the child's signs and symptoms to be shared with their peers for the purpose of helping identify when a medical incident occurs, I Ellisha Blair, hereby authorize such disclosure.

\* Signature of **Owner/Operator**

X	Date:
---	-------