** Emergency Care Plan**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fill out a separate emergency care plan for **each** health condition/diagnosis/allergy/sensitivity.

* Child has asthma
* Child has food allergy to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Child has insect sting allergy
* Child has latex allergy
* Child has seizures
* Child has other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a LIFE THREATENING condition? **YES**  or **NO**

Diagnosed by: **Parent** **Health Care Provider** **Non-Diagnosed**

Severity of food allergy? **Intolerance Only** **Mild** **Moderate** **Severe** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What can trigger a reaction? **Eating It** **Touching It** **Smelling It** **All** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention plan to avoid allergens at the center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the signs and symptoms that would indicate the need to implement the emergency plan (examples listed on back of form):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If the child develops the symptom listed, the team will:

* **Call 911**
* **Administer prescribed epinephrine injector/ Epi-Pen**
* **Administer prescribed medication**
* **Call Parent**

Staff will accommodate for children with chronic medical conditions and/or special needs during an emergency by following individual emergency plans such as Individualized Education Program (IEP), Emergency Care Plans, and Action Plans.

Staff responsible for assisting child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff responsible for transporting medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evacuation Accommodation Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shelter-In-Place Accommodation Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lock Down Accommodation Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/guardians must complete a medical authorization form for any medication the staff will administer. Staff will complete the Medication Authorization Form whenever they dispense medication to a child.

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of training**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Training conducted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have helped develop this Emergency Care Plan on \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date). I will communicate with my child’s teacher regarding any changes in treatment or diagnosis. I understand if my child’s medication expires, s/he may be unable to attend school until we have a current prescription.**

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All staff, including subs, will review this document at orientation and again within four months if not sooner:

Date Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Orientation) All Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Policy:** NMCAA will use the Emergency Care Plan to document chronic medical conditions, child specific health care needs, allergies and any other general concerns. This is a plan of action for child emergencies requiring rapid response. Safety training for prevention and response to emergencies will be provided as needed.

**Procedure:** This form must be completed at orientation with parent/guardian. All staff must review and initial at least twice a year. Attach the Emergency Care Plan to the Child Information Record in the Grab and Go Binder and on the bus. Transfer information onto the Allergy and Health Monitoring Form. Ensure conditions on the Child Information Record match those on the Emergency Care Plan.

A few reminders:

* **Fill out an Illness/Incident Report when non-emergency changes are observed in a child’s.**
* **Use an Incident Report-State of Michigan (BCAL - 4605) for emergency situations.**
* **These forms must be completed and sent home on the date of the incident/emergency.**

**Symptoms of an Allergic Reaction**

**All symptoms can potentially progress to a LIFE-THREATENING situation**.

GENERAL: Dizziness, loss of conscience, feeling of panic or doom

MOUTH: Swelling of lips, tongue, face, throat, mouth may “feel hot”

BREATHING: Wheezing, breathing difficulty, congestion, cough, throat tightness

STOMACH: Discomfort, nausea, vomiting, abdominal cramps, diarrhea

SKIN: Hives, rash, swelling

**Symptoms of an Asthma Episode:**

Changes in Breathing: Coughing, wheezing, mouth breathing, shortness of breath

Verbal Reports of: Chest tightness, chest pain, can’t breathe, neck feels funny, difficulty speaking

Appears: Anxious, sweating, nauseous, fatigued, stands/sits hunched over, cannot speak

**Symptoms of a Seizure Episode:** (may include any/all of these)

Tonic-Clonic (Grand mal) Seizure: Entire body stiffens, jerking movements, may cry out, turn bluish, be tired afterwards

Absence (Petite mal) Seizure: Staring spell, may blink eyes, loss of eye contact, twitching of arms or leg muscles

Original: Place behind the Child Information Record (add to the child’s file at the end of the year)

Copy: Parent, Site Supervisor, CCSC, and Bus Driver

Reference: R400.8161 (8), HSPPS 1302.41 (a)(b), HSPPS 1302.47 (7)(iv)(vi)

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