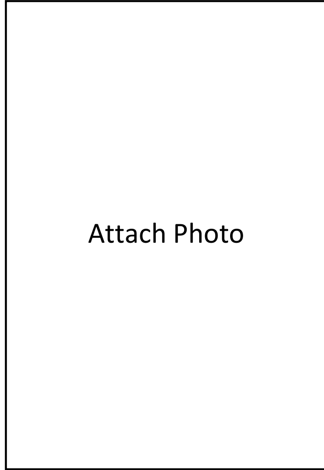
Life Threatening Allergy Alert Form



Participant's Full Name: ________________________________ Age: ___________

DOB: ______ /______ /______ Health Card No: ________________________
(Day / Month / Year)

This child has a life-threatening anaphylactic allergic reaction to:

______________________________ ☐ Taste ☐ Touch ☐ Smell

______________________________ ☐ Taste ☐ Touch ☐ Smell

______________________________ ☐ Taste ☐ Touch ☐ Smell

Common signs of an anaphylactic reaction (circle):

- Flushing
- Tingling of lips and mouth
- Itching eyes, nose, face
- Swelling of eyes and face
- Hives
- Vomiting
- Weakness and dizziness
- Swelling of throat
- Inability to breath
- Loss of consciousness
- Wheezing
- Diarrhea

Emergency Contact Information:

Parent/Guardian 1 (name): _____________________________ Relationship: ___________________

Phone (H)__________________ Phone (W) __________________Phone (C) ________________

Parent/Guardian 2 (name): _____________________________ Relationship: ___________________

Phone (H)__________________ Phone (W) __________________Phone (C) ________________

****Emergency Action Plan****

Act immediately and **do not** leave the child alone. Listen to the child. Believe what the child is telling you.

1. Give the prescribed medications:

Drug Name ________________________________ ________________________________

Instructions ____ ____

2. Call 911

3. Notify the parents/guardians.

TERMS AND CONDITIONS FOR CAG STAFF TO ADMINISTER, AND SUPERVISE THE ADMINISTRATION OR STORE PARTICIPANT MEDICATION

PLEASE READ CAREFULLY

1. I agree to provide CAG staff with:

- All non-prescription medication in its original container dated and labeled with the client's name and a completed and signed ***Medical Administration Form***. I understand that CAG staff will ask for a written physician's order before agreeing to administer, store or supervise the administration of non-prescription medication.
- All prescription medication in the original container dated, labeled, and supplied by the pharmacist as well as a completed and signed ***Medical Administration Form***. The label will contain - the participant's name, the physician's name, the name of the medication, the dose, the medication route, the schedule for administration, and instructions for storage.
- Two current photographs if there is a requirement to administer emergency medication, i.e., Epi-Pen®. I understand that the photograph will be affixed to a completed and signed ***Life Threatening Allergy Alert Form*** and will be publicly displayed. The photographs must be a clear, in-focus, headshot.

2. I understand that CAG staff may refuse to administer, supervise the administration, or store medication where the labels on the medication container(s) do not contain all the information specified above.

3. I consent to the **Emergency Action Plan**, outlined on page one.

4. I understand that not all CAG staff participating in medication administration are trained health professionals and that the administration of medication is being provided by or, on behalf of CAG, on a purely voluntary and gratuitous basis. As the participant or Parent/Legal guardian of the Participant/Client receiving medication, I fully understand the nature and extent of the risks involved in administering medication.

   I confirm that I have read and understood and completed this agreement. I am aware that by signing this agreement I have agreed to assume full legal liability for all risks involved in having CAG administer medication under the provisions of this agreement to the named participant.
   I authorize CAG to (Please check the appropriate box):

☐ Supervise the named participant in the administration of his/her own medication.

☐ Administer medication to the named participant.

____

Name of Participant or Parent/Guardian (if the participant is under the age of 18)

____

Signature of Participant or Parent/Guardian (if the participant is under the age of 18)

Date: ___________ / _____________________ / ___________________
MM DD YYYY