Life Threatening Allergy Form

Photo

Participant's Full Name:_____ Age:_____

DOB: _____ /_____ /_____ Health Card No:_____

(Day / Month / Year)

This child has a life threatening anaphylactic allergy reaction to:

_____	Taste	Touch	Smell
_____	Taste	Touch	Smell
_____	Taste	Touch	Smell

Common signs of an anaphylactic reaction:

- 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 Action Plan

1. Act immediately and do not leave child alone.
2. Listen to the child.
3. Believe what the child is telling you.
4. Give prescribed medications

Drug Name	Drug Instructions
_____	_____
_____	_____

5. Call 911
6. Notify Parent/ guardians

TERMS AND CONDITIONS FOR GNAG STAFF TO ADMINISTER, SUPERVISE THE ADMINISTRATION OF OR STORE PARTICIPANT MEDICATION. **PLEASE READ CAREFULLY**

1. I agree to provide GNAG staff with:
   - All non-prescription medication in its original container dated and labeled with the clients name. I understand that GNAG staff has the right to ask for a 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. 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 instruction for storage.
   - Two current photographs if there is a requirement to administer emergency medication, i.e. Epipen®.
2. I agree that GNAG 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 and administration of the prescribed mediations as outlined above.
4. I understand that not all GNAG staff participating in medication administration are trained health professionals and that the administration of medication is being provided by or, on behalf of GNAG, 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 GNAG administer medication under the provisions of this agreement to the named participant.

I authorize GNAG 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 (if participant is under 18 years) PLEASE PRINT

_____

Name of Parent/Guardian PLEASE PRINT

_____

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

_____

Date: _____ / _____ / _____

(Day / Month / Year)

Contact Info

Parent 1: Phone (C)_____ Phone (W) _____Phone (H) _____

Parent 2: Phone (C)_____ Phone (W) _____Phone (H) _____