



MILESTONE MONTESSORI

Unit 20 & 21, 279 Kingston Road East
Ajax, Ontario
L1Z 0K5

(905) 426-4367
info@milestonemontessori.ca
www.milestonemontessori.ca

ANAPHYLAXIS ALERT AND EMERGENCY PLAN

Name of child: _____

Date of Birth: _____ Height: _____

Sex: _____ Weight: _____

Classroom/Program: _____

Parent/Guardian: _____

Telephone (Home): _____

Telephone (Work): _____

Allergy Description: _____

The key to preventing an anaphylactic emergency is ABSOLUTE AVOIDANCE of the allergen.

SIGNS and SYMPTOMS

Please put a "X" in boxes that has symptoms specific to your child

- [] Tingling itchiness or metallic taste in mouth
- [] Watery eyes and nose, sneezing
- [] Hives, redness, generalized flushing, rash itching
- [] Swelling of the eyes, ears, lips, tongue, face, and skin
- [] Itchiness or tightness in throat, and/or chest
- [] Wheezing, hoarseness, hacking cough
- [] Nausea, vomiting, stomach pain, and/or diarrhea
- [] Dizziness, unsteadiness, drowsiness, feeling of impending doom
- [] Fall in blood pressure
- [] Loss of consciousness
- [] Coma and death
- [] Other (Please specify): _____

INDIVIDUAL EMERGENCY PLAN (to be completed by parent/guardian or physician)

Signature _____ Relationship to child _____ Date _____

Epi-Pens: in the event that your child requires an Epi-Pen for anaphylactic shock, you are required to supply **two pens** for your child. **These pens will remain within the child care at all times.** The epi-pens will be stored in their own separate pouch labeled with your child's name. This pouch will be carried by your child's teacher and will follow your child during their time in our care. **Note:** It is the parents' responsibility to provide additional Epi-pens for school-aged children (JK-Gr. 6). The child care Epi-pens will not follow your child to other programs (i.e. school) outside the child care program. You are also required to complete this form as accurately as possible. Please be aware that this form will be posted in two locations, the child's classroom and the child care office.



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MILESTONE MONTESSORI CASA PROGRAM ASTHMA MEDICATION INFORMATION AND CONSENT FORM

To be completed by the parent or guardian. Use one form for each medication.

Child's Name:	Medication:
Doctor's Name:	

Reason for medication: _____

When to give medication: _____

I authorize that my child may administer his or her own asthma medication.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date



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DIAPER CREAM/OINTMENT CONSENT

1. Diaper cream/ointment shall remain in the container in which it was purchased.
2. Diaper cream/ointment shall be clearly labeled with the child's first and last name.
3. Diaper cream/ointment will only be administered to the child whose name appears on the container.
4. Diaper cream/ointment will only be administered if current authorization is on file.

Child's Name: _____

Brand of Diaper Cream: _____

Apply Diaper Cream: (Check one)

After Every Diaper Change

When Diaper Rash/Redness is Present

Comments: _____

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date



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MILESTONE MONTESSORI EMERGENCY MEDICATION INFORMATION AND CONSENT FORM

To be completed by the parent or guardian. Use one form for each medication.

Child's Name:	Medication:
Doctor's Name:	

Reason for medication: _____

When to give medication: _____

We will give this medication exactly as shown on the label only.

I authorize Milestone Montessori to administer the medication named above to my child when needed, and I certify that the instructions given are as recommended by a physician.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date



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MILESTONE MONTESSORI MEDICATION INFORMATION AND CONSENT FORM

To be completed by the parent or guardian. Use one form for each medication.

Child's Name:	Medication:
Doctor's Name:	

Reason for medication: _____

Please circle one:

- 1. Prescription Drugs:** We will administer this medication or drug exactly as shown on the label only.
- 2. Non-prescription Drugs:** We will administer this only when recommended by your doctor.

Complete for either 1 or 2	
Dosage:	Method of Administration:
Start On:	Last day:
Frequency:	
Other Instructions:	
Side effects to be aware of:	

I authorize Milestone Montessori to administer the medication named above to my child when needed, and I certify that the instructions given are as recommended by a physician.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date



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SUNBLOCK/SUNSCREEN CONSENT

I hereby request that the following sunblock/sunscreen be administered to my child by a child care staff member of Milestone Montessori. I understand that I must supply Milestone Montessori with the sunblock in the original container labeled with the child's name, name of the sunblock, and the directions of administration.

I understand that sunscreen may be applied to the exposed skin including but not limited to the face, tops of the ears, nose and bare shoulders arms and legs.

Name of Child: _____ Date of Birth: _____

Name of Sunblock/Sunscreen: _____

I have administered at least one dose of the above sunblock/sunscreen to my child without adverse side effects.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date