Allergy Emergency Action Plan Place Name: ______Teacher: _____ Child's Picture ALLERGY TO: Here Asthmatic Yes* No *Higher risk for severe reaction STEP 1: TREATMENT Give Checked Medication**: **(To be determined by physician authorizing Symptoms: treatment) ☐ Epinephrine ☐ Antihistamine If an exposure to the allergen occurs, but no symptoms: ☐ Epinephrine ☐ Antihistamine Itching, tingling, or swelling of lips, tongue, mouth Mouth ☐ Epinephrine ☐ Antihistamine Hives, itchy rash, swelling of the face or extremities Skin ☐ Antihistamine Nausea, abdominal cramps, vomiting, diarrhea ☐ Epinephrine Gut ☐ Antihistamine ☐ Epinephrine Throat† Tightening of throat, hoarseness, hacking cough ☐ Antihistamine Shortness of breath, repetitive coughing, wheezing ☐ Epinephrine Lung† Weak or thready pulse, low blood pressure, fainting, pale, blueness ☐ Epinephrine ☐ Antihistamine Heart† ☐ Epinephrine . Antihistamine Other† ☐ Epinephrine ☐ Antihistamine If reaction is progressing (several of the above areas affected), give: † Potentially life-threatening. The severity of symptoms can quickly change. DOSAGE Twinject® 0.3 mg Twinject® 0.15 mg Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. (see reverse side for instructions) Other: give medication/dose/route IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis. STEP 2: EMERGENCY CALLS 1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed. 2. Dr. Phone Number: 3. Father______ Home_____ Cell_____ Work_____ Mother Home Cell Work 4. Emergency contacts: Name/Relationship: a. Home Cell Work Cell_____Work___ Home EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent' Signature Date

Doctor's Signature

Date