

Child's Last Name	Child's First Name	Date of Birth
Parent/Guardian Last Name		Parent/Guardian First Name
Allergy to	Asthmatic <input type="checkbox"/> Yes (Higher risk) <input type="checkbox"/> No	

STEP 1: TREATMENT SYMPTOMS

- If a food allergen has been ingested, but *no symptoms*:
- Mouth - *Itching, tingling, or swelling of lips, tongue, mouth*
- Skin - *Hives, itchy rash, swelling of the face or extremities*
- Gut - *Nausea, abdominal cramps, vomiting, diarrhea*
- Throat† - *Tightening of throat, hoarseness, hacking cough*
- Lung† - *Shortness of breath, repetitive coughing, wheezing*
- Heart† - *Thready pulse, low blood pressure, fainting, pale, blueness*
- Other† _____
- If reaction is progressing (several of the above areas affected), give

GIVE CHECKED MEDICATION

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Last Name _____ First Name _____

Home # _____ Cell # _____ Relationship _____

Last Name _____ First Name _____

Home # _____ Cell # _____ Relationship _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

