

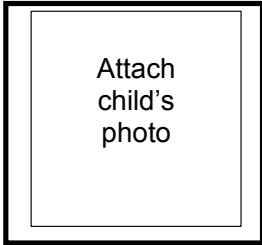


# Allergy and Anaphylaxis Emergency Plan

Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Weight: \_\_\_\_\_kg

Child has allergy to \_\_\_\_\_



- Child has asthma.  Yes  No (If yes, higher chance severe reaction)  
 Child has had anaphylaxis.  Yes  No  
 Child may carry medicine.  Yes  No  
 Child may give him/herself medicine.  Yes  No (If child refuses/is unable to self-treat, an adult must give medicine)

**IMPORTANT REMINDER**

**Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.**

<p><b>For Severe Allergy and Anaphylaxis</b> <b>What to look for</b></p> <p>If child has ANY of these severe symptoms after eating the food or having a sting, <b>give epinephrine.</b></p> <ul style="list-style-type: none"> <li>• Shortness of breath, wheezing, or coughing</li> <li>• Skin color is pale or has a bluish color</li> <li>• Weak pulse</li> <li>• Fainting or dizziness</li> <li>• Tight or hoarse throat</li> <li>• Trouble breathing or swallowing</li> <li>• Swelling of lips or tongue that bother breathing</li> <li>• Vomiting or diarrhea (if severe or combined with other symptoms)</li> <li>• Many hives or redness over body</li> <li>• Feeling of "doom," confusion, altered consciousness, or agitation</li> </ul> <p><input type="checkbox"/> <b>SPECIAL SITUATION:</b> If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, <b>give epinephrine.</b></p>		<p><b>Give epinephrine!</b> <b>What to do</b></p> <ol style="list-style-type: none"> <li>1. Inject epinephrine right away! Note time when epinephrine was given.</li> <li>2. Call 911.                     <ul style="list-style-type: none"> <li>• Ask for ambulance with epinephrine.</li> <li>• Tell rescue squad when epinephrine was given.</li> </ul> </li> <li>3. Stay with child and:                     <ul style="list-style-type: none"> <li>• Call parents and child's doctor.</li> <li>• Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.</li> <li>• Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.</li> </ul> </li> <li>4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.                     <ul style="list-style-type: none"> <li>• Antihistamine</li> <li>• Inhaler/bronchodilator</li> </ul> </li> </ol>
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<p><b>For Mild Allergic Reaction</b> <b>What to look for</b></p> <p>If child has had any mild symptoms, <b>monitor child.</b></p> <p>Symptoms may include:</p> <ul style="list-style-type: none"> <li>• Itchy nose, sneezing, itchy mouth</li> <li>• A few hives</li> <li>• Mild stomach nausea or discomfort</li> </ul>		<p><b>Monitor child</b> <b>What to do</b></p> <p>Stay with child and:</p> <ul style="list-style-type: none"> <li>• Watch child closely.</li> <li>• Give antihistamine (if prescribed).</li> <li>• Call parents and child's doctor.</li> <li>• If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")</li> </ul>
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**Medicines/Doses**

Epinephrine, intramuscular (list type): \_\_\_\_\_ Dose:  0.10 mg (7.5 kg to 15 kg)  
 0.15 mg (15 kg to 25 kg)  
 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): \_\_\_\_\_

Other (for example, inhaler/bronchodilator if child has asthma): \_\_\_\_\_

**Parent/Guardian Authorization Signature**      **Date**      **Physician/HCP Authorization Signature**      **Date**

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# Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

## Additional Instructions:

## Contacts

Call 911 / Rescue squad: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

### Other Emergency Contacts

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Return Form To:

School: \_\_\_\_\_ Fax: \_\_\_\_\_

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