Allergy Emergency Action Plan

Child's Name:_____ D.O.B._____

Weight:_____ Height:_____

Asthma: ☐ Yes (higher risk for severe reaction) ☐ No

Allergy to:_____

Extremely reactive to the following allergens:_____

_____

I _____ give permission for Food Explorers to administer epinephrine if an allergen has been consumed or likely consumed.

I _____ do not give permission for Food Explorers to administer epinephrine if an allergen has been consumed or likely consumed.

Symptoms:

If child has ANY of these **severe** symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing

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- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of “doom,” confusion, altered consciousness, or Agitation

If child has any of these **mild** symptoms, (Please check applicable box)

☐ Give antihistamine and monitor ☐ Monitor

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Additional instructions:

_____

_____

Medication/Doses

Epinephrine Brand/Dose:_____

Antihistamine Brand/Dose:_____

Physician Name and Phone Number: _____

_____

Parent/Guardian Name (Please print) Date

_____

Parent/Guardian Signature