

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Emergency Contact Person:	Contact Phone(s):	
Healthcare Provider Name(s):	Phone:	

## ALLERGY TO:

Asthmatic  Yes\*  No \* Higher risk for severe reaction

## STEP 1: TREATMENT

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

### 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

The severity of symptoms can quickly change. †Potentially life-threatening.

### GIVE CHECKED MEDICATION

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

### MEDICATION DOSAGE & ROUTE

#### Antihistamine:

Dose: \_\_\_\_\_

#### Epinephrine:

Inject epinephrine in thigh using (check one):

- |  |   |
|--|---|
| <input type="checkbox"/> Adrenaclick (0.15 mg) | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> EpiPen Jr (0.15 mg)   | <input type="checkbox"/> EpiPen (0.3 mg)      |

Epinephrine Injection, USP Auto-injector- authorized generic

- |  |   |
|--|---|
| <input type="checkbox"/> (0.15 mg)       | <input type="checkbox"/> (0.3 mg)       |
| <input type="checkbox"/> Other (0.15 mg) | <input type="checkbox"/> Other (0.3 mg) |

Other: \_\_\_\_\_

(PRINTED NAME OF PHYSICIAN)

(SIGNATURE OF PHYSICIAN / DATE)

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

## STEP 2: EMERGENCY CALLS

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR CALL 911!

① Call 911 . State that an allergic reaction has been treated, and additional epinephrine may be needed.

② Parent/Guardian Name(s):	Contact Phone(s):	Cell Phone(s):
③ Emergency Contact Person:	Contact Phone(s):	

Parent/Guardian Signature \_\_\_\_\_

DATE \_\_\_\_\_