

## ALLERGY EMERGENCY CARE PLAN (AGES 3 AND UP)



|                                                                                                                                      |                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Name _____                                                                                                                           | Date of Birth _____                                                                              |
| Allergic to _____                                                                                                                    | Asthma <input type="checkbox"/> Yes (higher risk of severe reaction) <input type="checkbox"/> No |
| Child trained and able to self-administer epinephrine <input type="checkbox"/> Yes (may need assistance) <input type="checkbox"/> No | Contact phone number _____                                                                       |
| Contact name _____                                                                                                                   | Allergist/doctor phone number _____                                                              |
| Allergist/doctor name _____                                                                                                          | Date _____                                                                                       |
| Allergist/doctor signature _____                                                                                                     |                                                                                                  |

### IF YOUR CHILD IS HAVING MILD SYMPTOMS:

SKIN: A few hives, mild itch, lip swelling  
NOSE: Itchy, runny nose, sneezing  
GUT: Mild nausea, discomfort, single vomit

DO THIS

1. Stay with child and give antihistamine.
2. If two or more mild symptoms present or symptoms progress. **GIVE EPINEPHRINE** and follow directions below.

### IF YOUR CHILD IS HAVING SEVERE SYMPTOMS:

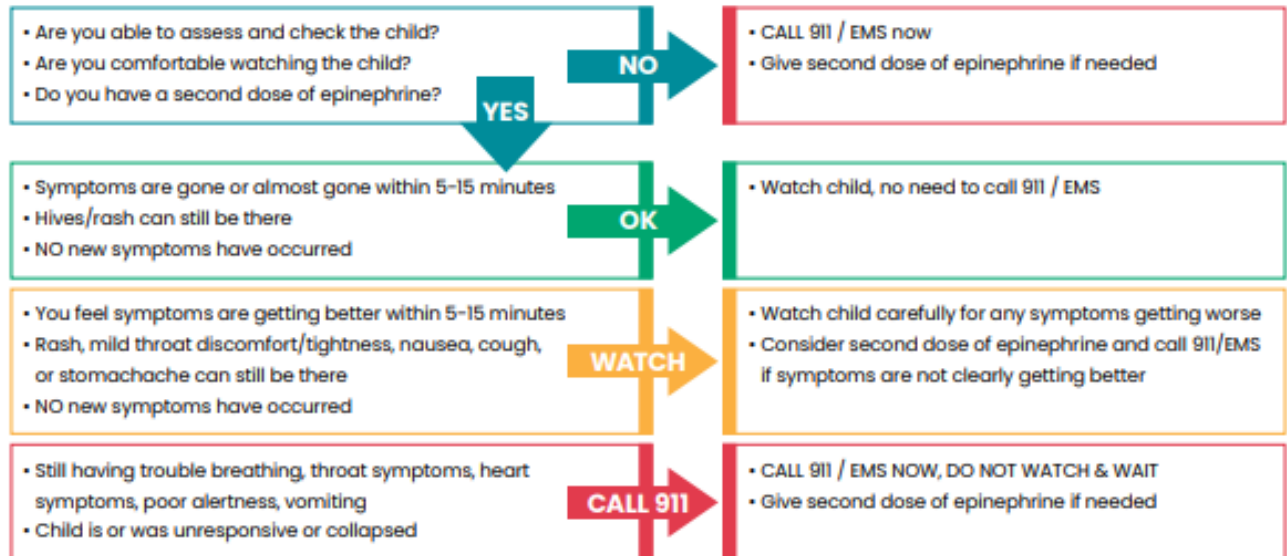
LUNGS: Shortness of breath, wheeze, coughing  
MOUTH: Visible swelling of the tongue  
THROAT: Tight, hoarse, trouble swallowing  
SKIN: Many hives over body, widespread red/purple/gray color

HEART: Faint, weak pulse, dizzy, pale, blue/gray skin, lips, nails  
GUT: Ongoing vomiting or diarrhea  
OTHER: Instinct detects danger, confused/agitated

1. **GIVE EPINEPHRINE right away and note the time when it is given. Stay with your child.** For heart symptoms or if two doses epinephrine given, lay child on their back with their legs raised. If it is hard for the child to breathe or they are throwing up, it is ok for them to sit or lay on their side.

2. Next, when to **WATCH AND WAIT** and when to **CALL 911 EMERGENCY MEDICAL SERVICES (EMS)**:

Call 911/EMS at any time, for any symptom, if you are not comfortable or if your doctor told you to do so after using epinephrine.



4. Give asthma quick-relief/rescue inhaler (see below) if your child has asthma.

5. Give antihistamine (see below).

### Medications:

#### Epinephrine Auto-injector:

☐ 0.15 mg ☐ 0.3 mg

(inject outside thigh)

#### Epinephrine Nasal Spray:

☐ 1 mg ☐ 2 mg

(1 spray to nostril)

#### Asthma Quick Relief/Rescue Inhaler:

☐ Albuterol \_\_\_\_\_ puffs

☐ Albuterol/Budesonide \_\_\_\_\_ puffs

☐ Salbutamol \_\_\_\_\_ puffs

☐ Budesonide/Formoterol \_\_\_\_\_ puffs

☐ Mometasone/Formoterol \_\_\_\_\_ puffs

#### Antihistamine\*:

☐ Cetirizine \_\_\_\_\_ mg

☐ Fexofenadine \_\_\_\_\_ mg

☐ Other: \_\_\_\_\_

\*Use epinephrine first for severe symptoms

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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