

Anaphylaxis Care Plan



For children with multiple allergies, use one form for each allergen.

Student Information:

Full Name (*last, first*): _____ DOB: _____

Allergy to: _____

Please be specific, especially for dairy product allergies

History of Asthma: **Yes**, high risk for severe reaction: _____ **No**: _____

Signs of an allergic reaction include:

systems

MOUTH

THROAT *

SKIN

GUT

LUNG *

HEART *

symptoms

Itching and swelling of lips, tongue or mouth.

Itching and/or a sense of tightness in the throat, hoarseness and hacking cough.

Hives, itchy rash and/or swelling about the face or extremities.

Nausea, abdominal cramps, vomiting and/or diarrhea.

Shortness of breath, repetitive coughing and/or wheezing.

"Thready" pulse and/or "passing out."

*The severity of symptoms can change quickly. *All of the above symptoms can potentially progress to a life-threatening situation.*

Action:

prescriber should number in order all appropriate actions:

_____ Observe child for severe symptoms.

_____ Administer EpiPen® before symptoms occur.

_____ Administer EpiPen® if symptoms occur.

_____ Administer Benadryl® (dose) _____ or Atarax® (dose) _____.

_____ Call 911 (and request a paramedic) and transport to ER if symptoms occur.

_____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given.

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!**

Parent Signature Date Prescriber Signature MD/APRN/PA Date

Parent Name, please print Prescriber Address & Phone #