ANAPHYLAXIS ACTION PLAN **Date:** _____

Name: _____ **Age/DOB:** _____

Allergy: ☐ Insect Sting ☐Food ☐Latex ☐Medication

Food Allergies: _____

Other: _____

History of anaphylaxis: ☐Yes ☐No

History of asthma (high risk for severe reaction): ☐Yes ☐No

Other health problems besides anaphylaxis: _____

Other currently used medications: _____

Signs & Symptoms of Anaphylaxis May appear anxious or express a sense of pending doom

MOUTH itching, swelling of lips and/or tongue

THROAT* itching, tightness/closure, hoarseness

SKIN itching, hives, redness, swelling

GUT vomiting, diarrhea, cramps

LUNG* shortness of breath, cough, wheeze

HEART* weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.

****Some symptoms can be life-threatening - ACT FAST!***

ADMINISTER EPINEPHRINE IMMEDIATELY if <u>two or more</u> of above symptoms are present or <u>one</u> symptom after a known allergen exposure.

EPINEPHRINE IS THE FIRST LINE OF TREATMENT!

What to do in order of importance:

1. **ACT IMMEDIATELY:** Inject Auto-Injectable Epinephrine in thigh
   - EpiPen Jr. (0.15mg)
   - EpiPen (0.3 mg)
   - Other Auto-Injectable Epinephrine _____
2. **Call 911** or Rescue Squad
3. After giving epinephrine, lay the person on his back and raise the legs, as respiratory status tolerates, until the ambulance arrives. Observe for signs of improvement.
4. **If no improvement in 5-15 minutes, give second dose of epinephrine.**
5. Additional medications to be given: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS

EVENT REPORT: Please complete and send with patient to emergency department

Circle any symptoms above that were reported by patient or that you observed

Time patient first reported symptoms: _____ Date: _____

Time of first dose: _____ Time of second dose: _____

Name/Signature of person giving injection/treatment: _____

EMERGENCY CONTACT #1:

Name:_____ Phone:_____

Relationship:_____

EMERGENCY CONTACT #2:

Name:_____ Phone:_____

Relationship:_____

EMERGENCY CONTACT #3:

Name:_____ Phone:_____

Relationship:_____

Comments:_____

Parent/guardian permission to treat immediately

Signature/Date: _____

Healthcare Provider

Name:_____ Phone:_____

Signature/Date: _____

* This information is for general purposes and is not intended to replace the advice of a qualified health professional.

** This form was adapted from forms created by the Allergy & Asthma Network, Anaphylaxis Community Experts and the American Academy of Allergy, Asthma & Immunology.

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