

ANAPHYLAXIS EMERGENCY ACTION PLAN

NAME: _____ AGE: _____

ALLERGY TO: _____

Asthma Yes (*high risk for severe reaction*) No

Other health problems besides anaphylaxis: _____

Concurrent medications, if any: _____

SYMPTOMS OF ANAPHYLAXIS INCLUDE:

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!*

WHAT TO DO:

1. INJECT EPINEPHRINE IN THIGH USING (check one): EpiPen Jr (0.15 mg) Twinject 0.15 mg
 EpiPen (0.3 mg) Twinject 0.3 mg

Other medication/dose/route: _____

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

2. CALL 911 or RESCUE SQUAD (BEFORE CALLING CONTACTS)!

3. Emergency contact #1: home _____ work _____ cell _____

Emergency contact #2: home _____ work _____ cell _____

Emergency contact #3: home _____ work _____ cell _____

DO NOT HESITATE TO GIVE EPINEPHRINE!

COMMENTS: _____

Doctor's Signature/Date

Parent's Signature (for individuals under age 18 yrs)/Date