

Emergency Medical Plan Template

Emergency Information for

(Name)

PHOTO

Life-threatening allergies to:

- | | |
|--|--|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> All nuts from trees (pecans, walnuts, etc.) |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Sesame seed/sesame oils | <input type="checkbox"/> Other: (indicate) _____ |

The following action must be taken immediately.

STEP 1. Determine how to treat reaction promptly.

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> <small>** (To be determined by physician authorizing treatment)</small>
<input type="checkbox"/> If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Throat:† Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Lung:† Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Heart:† Weak or thready pulse, low blood pressure, fainting , pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Other† _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†All of the above symptoms can progress to a life-threatening reaction.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2. Call 911 (or Rescue Squad _____) and request a paramedic with epinephrine. If epinephrine has already been given, state that more is required.

Emergency Contact Information:

Mother: Emergency cell phone: (_ _) _ _ - _ _ _ _

Home telephone: (_ _) _ _ - _ _ _ _

Work telephone: (_ _) _ _ - _ _ _ _

Father: Emergency cell phone: (_ _) _ _ - _ _ _ _

Home telephone: (_ _) _ _ - _ _ _ _

Work telephone: (_ _) _ _ - _ _ _ _

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature: _____

Date _____

Doctor's Signature _____

Date _____