American Academy of Allergy Asthma & Immunology
www.aaaai.org

# Anaphylaxis Emergency Action Plan

**Patient Name:** _____ **Age:** _____

**Allergies:** _____

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

**Additional health problems besides anaphylaxis:** _____

_____

**Concurrent medications:** _____

_____

**Symptoms of Anaphylaxis**

| | |
|---|---|
| MOUTH | itching, swelling of lips and/or tongue |
| THROAT* | itching, tightness/closure, hoarseness |
| SKIN | itching, hives, redness, swelling |
| GUT | vomiting, diarrhea, cramps |
| LUNGS* | 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!***

## Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

**1. Inject epinephrine in thigh using (check one):**

☐ **0.1 mg (16.5 lbs to less than 33 lbs) Specify brand:** _____

☐ **0.15 mg (33 lbs to less than 66 lbs) Specify brand:** _____

☐ **0.3 mg (66 lbs or more) Specify brand:** _____

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

**2. Call 911 or emergency medical services (before calling contact)**

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

**Emergency contact #2: home**_____ **work**_____ **cell**_____

**Emergency contact #3: home**_____ **work**_____ **cell**_____

**Comments:** _____

_____

_____

**Doctor's Signature/Date/Phone Number**

_____

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

# Medication Consent Form

**Handout 2.2**

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **This form is not required for over-the-counter diaper cream, sunscreen, insect repellant, lotion, lip balm or Vaseline.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-18 for prescription or OTC medication to be given more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state "consult a physician". Parent must also complete #19-22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

| 1. **CHILD's first and last name:** | 2. Date of birth: | 3. Child's known allergies: |
|---|---|---|
| 4. **Name of MEDICATION** (including strength): | 5. **Amount/DOSAGE to be given**: | 6. **ROUTE of administration**: |

7A. **FREQUENCY**: _____ **Specific TIME(s)** (e.g. 1p.m.): _____
**to administer**

***OR***

7B. Identify the **symptoms that will necessitate administration** of medication: (signs and symptoms must be observable and, when possible, measurable parameters).

8. **Possible side effects**: □ See package insert (parent must supply) *AND/OR* additional side effects:

9. What action should the child care provider take if side effects are noted:
□ Contact parent □ Contact prescriber at phone number provided below
□ Other (describe):

10. **Special instructions**: □ See package insert (parent must supply) *AND/OR* Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. **Reason the child is taking the medication** (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?
□ No □Yes If you checked yes, complete #25 and #27 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?
□ No □ Yes If you checked yes, complete #26 and #27 on the back of this form.

| 14. Date consent form completed: | 15. Date to be discontinued or length of time in days to be given (this date cannot exceed 12 months from the date authorized or this order will not be valid): |
|---|---|
| 16. **Prescriber's name** (please print): | 17. **Prescriber's telephone number**: |

18. **Licensed authorized prescriber's signature**:

Required for long-term (more than 10 working days) prescription medications, nebulizer or epinephrine auto-injector medications and when dosage directions state "consult a physician". Not required for over-the-counter medications/products applied to the skin.

**PARENT/GUARDIAN MUST COMPLETE THIS SECTION**

| | |
|---|---|
| 19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to (child's name) . | |
| 20. Parent or legal guardian's name (please print): | 21. Date authorized: |
| 22. Parent or legal guardian's signature: | |

**PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15**

| |
|---|
| 23. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed. |
| 24. Parent or Legal Guardian's Signature: |

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED**

| |
|---|
| 25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child. |
| |
| |
| |
| 26. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.<br>DATE:_____<br>By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled. |
| 27. Licensed Authorized Prescriber's Signature: |

**CHILD DAY PROGRAM TO COMPLETE THIS SECTION**

| | |
|---|---|
| 28. Provider/Facility name: | 29. Facility Phone Number: |
| I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program. | |
| 30. Authorized child care provider's name (please print): | 31. Date received from parent: |
| 32. Authorized child care provider's signature: | |

# FARE Food Allergy Research & Education

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

**PLACE PICTURE HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:**_____

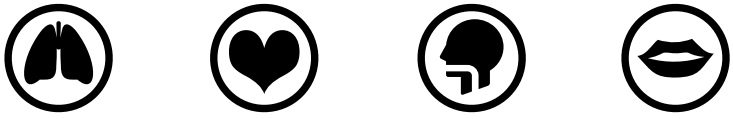
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

## **SEVERE** SYMPTOMS



**LUNG**
Shortness of breath, wheezing, repetitive cough

**HEART**
Pale or bluish skin, faintness, weak pulse, dizziness

**THROAT**
Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**
Significant swelling of the tongue or lips

**SKIN**
Many hives over body, widespread redness

**GUT**
Repetitive vomiting, severe diarrhea

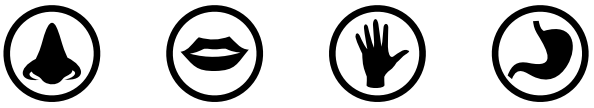
**OTHER**
Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## **MILD** SYMPTOMS



**NOSE**
Itchy or runny nose, sneezing

**MOUTH**
Itchy mouth

**SKIN**
A few hives, mild itch

**GUT**
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

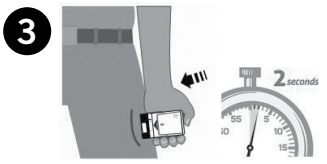
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

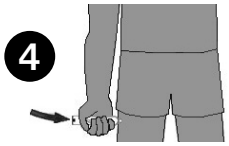
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



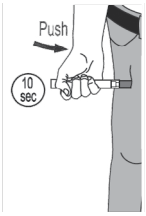

## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.




## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.


## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.


## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

## EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

## OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020