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 Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

_____ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Parent's or Guardian's Signature: _____ **Date:** _____

Section B: to be completed by child's physician

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Physician's Signature: _____ **Date:** _____

Physicians Phone: _____