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**
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!

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

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

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: _____

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

2. Call 911 or rescue squad (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

MAT

Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

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 to be administered: _____

OR

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

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: 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): _____

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. 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 requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 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 #35-#36 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 6 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 medication or when dosage directions state "consult a physician".

This is a double-sided form

Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ (child's name).

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility telephone number:	26. (leave blank)
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. 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.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child._____
34. Licensed Authorized Prescriber's Signature:
35. 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. DATE:_____ By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature:

This is a double-sided form