Anaphylaxis Emergency Plan

N/A: ☐

Name of Child: _____

My child is allergic to:

☐ Peanut ☐ Eggs ☐ Insect Sting ☐ Latex ☐ Medication ☐ Tree Nut ☐ Milk

Other (please specify): _____

Epinephrine auto-injector Expiry date: _____

Dosage: ☐ EpiPen Jr. 0.15mg ☐ EpiPen 0.30mg ☐ Twinject 0.15mg ☐ Twinject 0.30mg

Location of auto-injector: _____

☐ **Asthmatic** (Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication)

Please select/circle all symptoms your child has when experiencing an anaphylactic reaction:

☐	**Skin**	Hives, swelling, itching warmth, redness, rash
☐	**Respiratory**	Wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain / tightness, nasal congestion, trouble swallowing
☐	**Gastrointestinal**	Nausea, pain, cramps, vomiting, diarrhea
☐	**Cardiovascular**	Pale / blue colour, weak pulse, passing out, dizzy, shock
☐	**Other**	Anxiety, feeling of 'impending doom', headache

Emergency Contact Information

Name: _____ Relationship: _____

Cell Phone: _____ Day/Work Phone: _____

Name: _____ Relationship: _____

Cell Phone: _____ Day/Work Phone: _____

The undersigned parent or guardian authorizes any adult to administer epinephrine to the above named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

_____ _____ _____ _____

Parent/Guardian signature Date Physician signature Date