Trinity Preschool

ALLERGY / ASTHMA EMERGENCY ACTION PLAN

Child's Photograph

Child's Name: _____ **D.O.B.** (MM/DD/YY) ____/___/___

CLASS: ☐ **Twos** ☐ **Threes** ☐ **Pre-K** ☐ **Pre-K Boost**

☐ **SEVERE ALLERGY TO:** _____

☐ **MILD ALLERGY TO:** _____

☐ **ASTHMA** (higher risk for severe reaction) **Weight:** _____ lbs

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

☐ If checked, give epinephrine immediately, before symptoms if the allergen was ***definitely*** eaten.

SEVERE SYMPTOMS →

ONE OR MORE OF THE FOLLOWING:

- **LUNGS** Short of breath, wheezing, repetitive cough
- **HEART** Pale, blue, faint, weak pulse, dizzy
- **THROAT** Tight, hoarse, trouble breathing/swallowing
- **MOUTH** Obstructive swelling (tongue and/or lips)
- **SKIN** Many hives over body

OR A COMBINATION OF SYMPTOMS:

- **SKIN** Hives, itchy rashes, swelling (e.g., eyes, lips)
- **GUT** Vomiting, crampy pain

→ INJECT EPINEPHRINE IMMEDIATELY

- **CALL 911**
- BEGIN MONITORING (see below)
- Note time epinephrine was administered _____
- Give inhaler / bronchilator if asthmatic

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY →

ONE OR MORE OF THE FOLLOWING:

- **MOUTH** Itchy mouth
- **SKIN** A few hives around mouth / face, mild itch
- **GUT** Mild nausea/discomfort

→ GIVE ANTIHISTAMINE

- Stay with child; alert healthcare professionals and parent
- **IF SYMPTOMS PROGRESS, INJECT EPINEPHRINE** (see above)

MONITORING

Stay with the child; alert healthcare professionals and parent/guardian. Advise paramedics epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose may be administered 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

MEDICATIONS

EPINEPHRINE: Brand _____ Dose _____

ANTHIHISTAMINE Brand _____ Dose _____

OTHER (e.g. inhaler / bronchilator) Brand _____ Dose _____

EMERGENCY CONTACTS *Please print.*

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

_____ _____ _____ _____

Parent/Guardian Signature Date Physician/Healthcare Provider Date