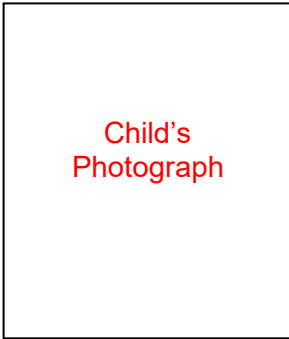


Trinity Preschool  
**ALLERGY / ASTHMA EMERGENCY ACTION PLAN**



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 \_\_\_\_\_

ANTHISTAMINE 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