

TRINITY PRESBYTERIAN PRESCHOOL
ALLERGY / ASTHMA EMERGENCY ACTION PLAN

CHILD'S NAME: _____ **D.O.B.** (MM/DD/YY) ____/____/____

CLASS: ____ AM TWOs ____ PM TWOs ____ TTH3s ____ MWF3s ____ MWF PK ____ PM PK

____ **SEVERE ALLERGY TO:** _____

____ **MILD ALLERGY TO:** _____

____ **ASTHMA** (higher risk for severe reaction)

Weight: _____ lbs

Child's
Photograph

____ 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. 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 _____

ANTHIIHISTAMINE Brand _____ Dose _____

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

EMERGENCY CONTACTS

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Parent/Guardian Signature

Date

Physician/Healthcare Provider

Date