TRINITY PRESBYTERIAN PRESCHOOL

ALLERGY / ASTHMA EMERGENCY ACTION PLAN

Child's Photograph

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**: ____

__ 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.

Weight: _______ lbs

___ ASTHMA (higher risk for severe reation)

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** Hives, itchy rashes, swelling (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

A second dose may be administered after 5 minutes if symptoms persist or recur.

MILD SYMPTOMS ONLY →

- **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

WHEN IN DOUBT, USE EPI PEN!
Symptoms can rapidly become more severe.
(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 ______________

ANTIHISTAMINE 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