

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_ D.o.B: \_\_\_\_\_

Allergies: \_\_\_\_\_

Asthma: Yes  No  Other conditions \_\_\_\_\_

**ALLERGIC REACTION TREATMENT:**

**Symptoms:**

If a child with allergies exhibits any of the following symptoms,

- |        |   |
|--------|---|
| Mouth  | Itching, swelling of lips and/or tongue |
| Throat | Itching, tightness/closure, hoarseness  |
| Skin   | Itching, hives, redness, swelling       |
| Gut    | Vomiting, diarrhea, cramps              |
| Lung   | Shortness of breath, cough, wheeze      |
| Heart  | Weak pulse, dizziness, passing out      |

**Then, give the child:**

Diphenhydramine HCl:	Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.
Other Antihistamine:	Medication: _____ Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.
Epinephrine <input type="checkbox"/> Epi Pen Jr <input type="checkbox"/> AviQ	Medication: _____ Dosage: _____ If rescue squad has not arrived within 15 minutes, should child be injected a second time?: Yes ___ No ___
Other Medication	Medication: _____ Dosage: _____ If condition does not improve within ___ minutes or seems to worsen, follow steps for a major reaction.

**OTHER CONDITION TREATMENT:**

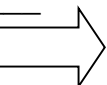
If a child with \_\_\_\_\_, presents with \_\_\_\_\_

\_\_\_\_\_

**Then, give the child:**

Other Medication	Medication: _____ Dosage: _____
Other Medication	Medication: _____ Dosage: _____

**Physician's Signature:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**EMERGENCY CALLS**

**\*\* CALL 911**

Parent 1: \_\_\_\_\_ Parent 2 \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to child \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone Number \_\_\_\_\_

Allergist or other Specialist: \_\_\_\_\_ Phone Number \_\_\_\_\_

My child has required the use of their emergency medication \_\_\_\_\_ times, most recently on \_\_\_\_\_.

This was necessary because he/she exhibited the following symptoms: \_\_\_\_\_

\_\_\_\_\_

The symptoms were caused by (food, bee, sting, etc.): \_\_\_\_\_

\_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\* All medication must be presented in original packaging and expire after the end of the current school year. \*\*\*\***