Peyton Manning Children's Hospital at St.Vincent

Allergy Care Plan

Patient Information

Student's Name _____ DOB _____ Grade _____

Allergy To: _____

Asthmatic: Yes* ____ No ___ (*Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	Give Checked Medication
If an allergen has been contacted, *but no symptoms*	___ Epinephrine ___ Antihistamine
Mouth Itchy, tingling, or selling of lips, tongue, and mouth	___ Epinephrine ___ Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	___ Epinephrine ___ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	___ Epinephrine ___ Antihistamine
Throat: tightening of throat, hoarseness, hacking cough	___ Epinephrine ___ Antihistamine
Lung: shortness of breath, repetitive coughing, wheezing	___ Epinephrine ___ Antihistamine
Heart: weak or thready pulse, hypotension, fainting, pale, blue	___ Epinephrine ___ Antihistamine
Other: _____	___ Epinephrine ___ Antihistamine

Dosage

Please Note: It is the responsibility of the parent/guardian to provide medication.
Epinephrine - Inject the following medication intramuscularly (check one)
❑EpiPen® 0.3mg ❑ EpiPen Jr.® 0.15mg
Antihistamine - Give _____ medication/dose/route
Other - Give _____ medication/dose/route
IMPORTANT: Inhalers for asthma and/or antihistamines cannot be depended on to replace Epinephrine in anaphylaxis.

STEP 2: EMERGENCY NOTIFICATION

1. Call 911. State that an allergic reaction has been treated, and additional Epinephrine may be needed.
2. Dr. _____ Phone Number _____
3. Parent _____ Phone Number _____
4. Emergency Contacts:

Name/Relationship	Phone Number
a._____	_____
b._____	_____

Do not hesitate to provide treatment or call 911 if parent cannot be contacted.

Signatures

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____