



AUTHORIZATION OF EMERGENCY TREATMENT

_____ is allergic to: _____

1. If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows:

Symptoms:

- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, swelling on face or extremities, itchy rash
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat Tightening of throat, hoarseness, hacking cough
- Lung Shortness of breath, repetitive coughing, wheezing,
- Heart Thready pulse, passing out, fainting, pale, blueness
- General: Panic, sudden fatigue, chills, fear of impending doom

If a food allergen has been ingested, but *no symptoms*:

If a reaction is progressing (several of the above areas affected):

Give Medication checked "X"*

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | |
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | |
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | |
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| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | |
| <input type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | |
| <input checked="" type="checkbox"/> Antihistamine | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Other |
| <input checked="" type="checkbox"/> Antihistamine | <input checked="" type="checkbox"/> EpiPen | |

Medication Doses:

Antihistamine (liquid diphenhydramine, Benadryl™ or cetirizine, Zyrtec™):

Give _____ Teaspoon(s), _____ cc (_____ mg) by mouth.

Epinephrine:

EpiPen™ [Epi-Pen _____ (_____ mg)] injected once into upper outer thigh

Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

Call 911 (or Ambulance service and phone number: _____)

State that the child had a severe allergic reaction, and additional epinephrine doses may be needed

Additional contact information:

Nearest Hospital _____ Phone _____ Address _____

Allergist Name _____ Phone _____

Pediatrician Name _____ Phone _____

Parent's Name (other contacts) and Contact Numbers

Name _____

Phone (1) _____ Phone (2) _____

Name _____

Phone (1) _____ Phone (2) _____

Other allergies, medication allergies, medical conditions: _____ Approximate Weight: _____ lbs

DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!

*Additional boxes may be checked depending upon specific patient history

Physician's Signature _____

Date _____

Parent's Signature _____

Date _____



Provided by the Food Allergy Initiative, a national non-profit organization dedicated to finding a cure to life-threatening food allergies. For more information, please visit www.FoodAllergyInitiative.org or email Info@FoodAllergyInitiative.org