

## Allergy / Anaphylaxis Physician Orders

**Student's Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

### 🕒 STEP 1: TREATMENT 🕒

<b>Symptoms:</b>	<b>Give Checked Medication**:</b> <small>** (To be determined by physician authorizing treatment)</small>
<input type="checkbox"/> If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Throat† Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Lung† Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> Other† _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
<input type="checkbox"/> If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

### DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

**Antihistamine:** give \_\_\_\_\_  
Medication/dose/route

**Other:** give \_\_\_\_\_  
Medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

### 🕒 STEP 2: EMERGENCY CALLS 🕒

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(s) \_\_\_\_\_

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____

b. _____	1.) _____	2.) _____
----------	-----------	-----------

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)