RyeNeckSchools
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Childs Photograph

AUTHORIZATION OF EMERGENCY TREATMENT

_____is allergic: _____

1. If you suspect that a food allergen has been ingested or an insect sting has occurred: immediately assess the symptoms and treat symptoms as follows:

Symptoms:	**Medication to be given:**
Mouth: Itching, tingling, or swelling of the lip, tongue, mouth	___Benadryl___EpiPen___Other
Skin: Hives, swelling on face or extremities, itchy rash	___Benadryl___EpiPen___Other
Gut: Nausea, abdominal cramps, vomiting, diarrhea	___Benadryl___EpiPen___Other
Lung: Tightening of throat hoarseness, hacking cough	___Benadryl___EpiPen___Other
Heart: Shortness of breath, repetitive coughing, wheezing	___Benadryl___EpiPen___Other
General: Panic, sudden fatigue, chills, fear of impending doom	___Benadryl___EpiPen___Other
Other: _____	___Benadryl___EpiPen___Other
If a food allergen has been ingested, but there are no symptoms:	___Benadryl___EpiPen___Other
If a reaction is progressing (several of the above areas affected):	___Benadryl___EpiPen___Other

Medication Doses:

Antihistamine (liquid diphenhydramine, Benadryl): Give _____Teaspoon(s), _____cc_____mg by mouth

Exp. Date of Medication:_____

Epinephrine (_____mg]) injected into outer upper thigh.

Exp. Date of Medication:_____

Call 911 (or ambulance service number_____) State that the child had a severe allergic reaction.

Additional Contact Information:

Nearest Hospital_____ Phone_____ Address_____

Allergist Name_____ Phone_____

Pediatrician Name_____ Phone _____

Parents name other contacts and contact numbers:

Name_____ Phone #1_____Phone#2_____

Name_____ Phone #1_____Phone#2_____

Other allergies, medication allergies, medical conditions: _____

Approximate weight_____

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

_____ _____

Physician's Signature Date Parent's Signature Date