

# Anaphylaxis Emergency Action Plan

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

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

Asthma  Yes (*high risk for severe reaction*)  No

Additional health problems besides anaphylaxis: \_\_\_\_\_

Concurrent medications: \_\_\_\_\_

|                |   |
|----------------|---|
|                | <b>Symptoms of Anaphylaxis</b>          |
| <b>MOUTH</b>   | itching, swelling of lips and/or tongue |
| <b>THROAT*</b> | itching, tightness/closure, hoarseness  |
| <b>SKIN</b>    | itching, hives, redness, swelling       |
| <b>GUT</b>     | vomiting, diarrhea, cramps              |
| <b>LUNG*</b>   | shortness of breath, cough, wheeze      |
| <b>HEART*</b>  | weak pulse, dizziness, passing out      |

*Only a few symptoms may be present. Severity of symptoms can change quickly.  
\*Some symptoms can be life-threatening. ACT FAST!*

## Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
- |   |   |
|---|---|
| <input type="checkbox"/> Adrenaclick (0.15 mg)                      | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> Auvi-Q (0.15 mg)                           | <input type="checkbox"/> Auvi-Q (0.3 mg)      |
| <input type="checkbox"/> EpiPen Jr (0.15 mg)                        | <input type="checkbox"/> EpiPen (0.3 mg)      |
| <b>Epinephrine Injection, USP Auto-injector- authorized generic</b> |   |
| <input type="checkbox"/> (0.15 mg)                                  | <input type="checkbox"/> (0.3 mg)             |
| <input type="checkbox"/> Other (0.15 mg)                            | <input type="checkbox"/> Other (0.3 mg)       |

Specify others: \_\_\_\_\_

**IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.**

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency contact #2: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Emergency contact #3: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature/Date/Phone Number

\_\_\_\_\_  
Parent's Signature (for individuals under age 18 yrs)/Date