



Anaphylaxis Emergency Action Plan

Patient Name: _____ Age: _____

Allergies: _____

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

Additional health problems besides anaphylaxis: _____

Concurrent medications: _____

	Symptoms of Anaphylaxis
MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	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"/> Adrenacllick (0.15 mg) | <input type="checkbox"/> Adrenacllick (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) |
| Epinephrine Injection, USP Auto-injector- authorized generic | |
| <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