EMERGENCY CARE PLAN
Food Allergy

Patient Name:

Patients DOB:

Address:

Physician's Name: **Physician's #:**

Diagnosis:

Asthma? Yes / No

Specific Allergen:

Food Allergy: **Touch:** **Ingestion:** **Aromatic:**

IF CHILD INGESTS OR THINKS HE/SHE INGESTED THE ABOVE NAMED FOOD OR IF CHILD IS STUNG FOLLOW THE NUMBER OF SEQUENCE OF ADMINISTRATION OF MEDS:

_____GIVE_____MGS (_____Tsp) OF BENADRYL

_____OBSERVE CHILD FOR SIGNS & SYMPTOMS

_____GIVE EPI-PEN JR 0.15MG or EPI-PEN 0.3MG BEFORE SYMPTOMS OCCUR- CALL 9-1-1

_____GIVE EPI-PEN JR 0.15MG or EPI-PEN 0.3MG IF SYMPTOMS OCCUR- CALL 9-1-1

_____TRANSPORT TO ER VIA 9-1-1

_____
Physician's Signature / Date

EMERGENCY PHONE NUMBERS:

1. Name/Relationship Phone: Home/Work/Cell

2. Name/Relationship Phone: Home/Work/Cell