0 2 3 4 7

Children's Hospital of The King's Daughters, Inc.
601 Children's Lane, Norfolk, VA 23507-1910

Allergy/Immunology Department

LIFE-THREATENING ALLERGY MANAGEMENT PLAN

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

To be completed by MD: Valid for Current School Year _____

Name: _____ **DOB:** _____ **Weight**_____

Allergy to: _____

Asthma: □ **Yes (high risk for severe reaction)** □ **No** □ **See Asthma Action Plan**

Extremely Reactive to:_____
If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:	Symptoms:
Mouth:	itchy mouth
Skin:	minor itching "and/or" a few hives
Gut:	mild nausea/discomfort

Liquid

□ **diphenhydramine** (12.5mg//5ml) **p.o.**
(can be repeated q 4-6 hours)
□ **cetirizine** (5mg/5ml) **p.o.**
(do not repeat)
Dose:_____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:	Symptoms:
MOUTH	swelling of the lips, tongue, or mouth
THROAT	tight throat, hoarseness, drooling, trouble swallowing
LUNG	shortness of breath, repetitive cough and/or wheezing
HEART	thready pulse, faint, confused, dizzy, pale, blue
SKIN	multiple hives, swelling about the face and neck
GUT	abdominal cramps, vomiting

1. Inject Epinephrine immediately intramuscularly
□ **Epipen®** □ **Epipen® Jr** □ **Auvi-Q™ 0.30mg** □ **Auvi-Q™ 0.15mg** □ _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT
- **Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.**

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.
- **Antihistamines and inhalers are not first line therapy in a severe reaction.**

4. Transport via EMS to the emergency department.

Emergency Contacts:
Parent/Guardian_____ Phone:_____
Other emergency contact_____ Phone:_____

_____ _____ _____ _____
Parents Signature **DATE** **DOCTOR'S SIGNATURE** **DATE:**

_____ _____ **Print MD Name:** _____
Nurses Signature **DATE** **Contact number:** _____