



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 _____

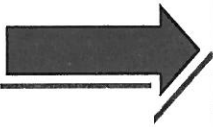
Allergy to: _____

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:

<u>Systems:</u>	<u>Symptoms:</u>
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)

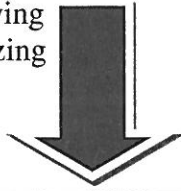
cetirizine (5mg/5ml) p.o.
(do not repeat)

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)

<u>Systems:</u>	<u>Symptoms:</u>
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: _____

Nurses Signature _____ DATE _____

Print MD Name: _____
Contact number: _____