American Academy of Allergy Asthma & Immunology
www.aaaai.org

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):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **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

Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

____Fredericksburg Academy_____has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
(Start date) **(End date)**

Parent's or Guardian's Signature: _____ **Date**: _____

Section B: to be completed by child's physician

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to:_____ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

_____

This authorization is effective from: _____until: _____
(Start date) **(End date)**

Physician's Signature: _____ **Date**: _____

Physicians Phone: _____