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 |
| LUNGS* | 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):**

☐ **0.1 mg (16.5 lbs to less than 33 lbs) Specify brand:** _____

☐ **0.15 mg (33 lbs to less than 66 lbs) Specify brand:** _____

☐ **0.3 mg (66 lbs or more) Specify brand:** _____

**IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.**

2. **Call 911 or emergency medical services (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)***

_____ 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: _____