Allergy/Anaphylaxis Physicians Orders

Student's Name:_____DOB:_____ School_____ Teacher_____

Symptoms	Give Checked Medications** (To be determined by physician authorizing treatment	
☐ If food allergen has been injested, but ***no symptoms***	☐ Epinephrine	☐ Antihistimine
☐ Mouth itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistimine
☐ Skin hives, itchy rash, swelling of face or extremities	☐ Epinephrine	☐ Antihistimine
☐ Gut nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistimine
☐ **Throat** tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistimine
☐ **Lung** shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistimine
☐ **Heart** weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistimine
☐ **Other**	☐ Epinephrine	☐ Antihistimine
☐ If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistimine

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐

*Higher risk for severe reaction.

STEP 1: TREATMENT

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give_____
Medication,/dose,/route

Other: give_____
Medication,/dose,/route

IMPORTANT: Asthma inhalers and/or antihistimines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number:_____
3. Parent_____ Phone Number:_____
4. Emergency Contacts:
   Name/Relationship Phone Number(s)

   a._____ 1)_____2)_____

   b._____ 1)_____2)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/ Guardian's Signature_____ Date_____

Doctor's Signature (Required)_____ Date_____