



ANAPHYLAXIS ACTION PLAN

_____/_____
 Name Age/DOB

History of asthma Yes No Allergies Yes No NOTE: "Yes" indicates increased risk factors.

Allergens known to trigger anaphylactic reactions for this person:

Epinephrine auto-injector brand name and dose:

NOTE: Epinephrine is always the FIRST medication given. Administer secondary medications if needed:

Patient has been taught how and when to use this epinephrine auto-injector: Yes No

NOTE: Due to the nature of anaphylaxis, the patient may or may not be able to self-administer medication during a crisis.

A Act immediately: Administer epinephrine auto-injector in thigh when:

C Call for help: 911/Rescue Squad. Speak to at least one person on the emergency contact list below.

E Expect RAPID results: IF NO IMPROVEMENT WITHIN 5 - 15 MINUTES, administer second epinephrine auto-injector dose.

EMERGENCY CONTACT INFORMATION:

_____ Name	_____ Phone	_____ Relationship
_____ Name	_____ Phone	_____ Relationship
_____ Name	_____ Phone	_____ Relationship
_____ Healthcare Provider Signature	_____ Contact Number	_____ Date
_____ Patient or Parent/Guardian of minor child	_____ Contact Number	_____ Date



Anaphylaxis Signs and Symptoms

The patient feels or notices symptoms before they become obvious to others.

- General sense of pending doom or anxiety.
- Shortness of breath, wheezing, coughing, shallow breathing
- Stomach cramps, nausea, vomiting, diarrhea
- Runny or itchy nose, sneezing
- Red or watery eyes
- Itchy mouth or throat
- Difficulty swallowing

Signs/symptoms that are more obvious:

- Lips and/or tongue swell
- Face or skin rashes, hives, swelling, redness, facial swelling
- Choking
- Weak pulse, low blood pressure, dizziness, passing out, loss of consciousness

It is not possible to predict future symptom severity based on prior experience. If a patient asks for help or says they are feeling any combination of symptoms upon exposure to a known or suspected allergen, treat the situation as a medical emergency and **follow the Anaphylaxis Action Plan** provided by the healthcare provider.

Anaphylaxis Event Report

To be completed and given to emergency responders to travel with the patient to the hospital. Also send any used epinephrine auto-injectors.

Circle any symptoms listed above that you observed or the patient reported.

Time first epinephrine dose was given: _____

Time second epinephrine dose was given: _____

Time patient first reported symptoms: _____

Notes/comments: _____

Name of person giving epinephrine auto-injector

Please PRINT and sign name

Date