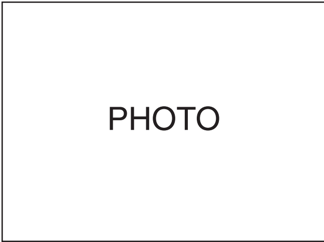

AUTHORIZATION OF EMERGENCY TREATMENT

______________________________________ is allergic to: ______________________________

1. If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows:

Symptoms:		**Give Medication checked "X"***		
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine	☐ EpiPen	
Skin	Hives, swelling on face or extremities, itchy rash	☐ Antihistamine	☐ EpiPen	
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine	☐ EpiPen	
Throat	Tightening of throat, hoarseness, hacking cough	☐ Antihistamine	☐ EpiPen	
Lung	Shortness of breath, repetitive coughing, wheezing,	☐ Antihistamine	☐ EpiPen	
Heart	Thready pulse, passing out, fainting, pale, blueness	☐ Antihistamine	☐ EpiPen	
General:	Panic, sudden fatigue, chills, fear of impending doom	☐ Antihistamine	☐ EpiPen	
If a food allergen has been ingested, but *no symptoms*:		☒ Antihistamine	☐ EpiPen	☐ Other
If a reaction is progressing (several of the above areas affected):		☒ **Antihistamine**	☒ **EpiPen**	

Medication Doses:
Antihistamine (liquid diphenhydramine, Benadryl™ or cetirizine, Zyrtec™):
Give ____________________ Teaspoon(s), _______cc (________mg) by mouth.
Epinephrine:
EpiPen™ [Epi-Pen_______ (________mg)] injected once into upper outer thigh
Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

Call 911 (or Ambulance service and phone number:____)
State that the child had a severe allergic reaction, and additional epinephrine doses may be needed

Additional contact information:
Nearest Hospital ______________________________ Phone ______________________________Address
Allergist Name ______________________________ Phone ______________________________
Pediatrician Name ______________________________ Phone ______________________________
Parent's Name (other contacts) and Contact Numbers
Name ______________________________
Phone (1) ______________________________ Phone (2) ______________________________
Name ______________________________
Phone (1) ______________________________ Phone (2) ______________________________
Other allergies, medication allergies, medical conditions:______________________________ Approximate Weight:_____ lbs

DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!

*Additional boxes may be checked depending upon specific patient history

______________________________ ______________________________
Physician's Signature Date Parent's Signature Date

Provided by the Food Allergy Initiative, a national non-profit organization dedicated to finding a cure to life-threatening food allergies. For more information, please visit www.FoodAllergyInitiative.org or email Info@FoodAllergyInitiative.org