STUDENT PICTURE

EMERGENCY TREATMENT PLAN
FOOD ALLERGY/STINGING INSECT

Patient's Name: _____ Date of Birth _____

Patient's Address: _____

Physician's Name: _____ Physician's Phone #: _____

History of Asthma: ☐ Yes (high risk for severe reaction) ☐ No

Diagnosis: _____

Specific Food Allergen: _____

If Patient Ingests or Thinks He Ingested the Above-Named Food:

_____ _____ Observe patient for symptoms of anaphylaxis **

_____ _____ Administer epinephrine before symptoms occur

_____ _____ Administer epinephrine if symptoms occur

_____ _____ Administer Benadryl _____ or Atarax _____

_____ _____ Transport to ER if symptoms occur

_____ _____ Call 911 EMS and transport to ER if Epi-Pen given

_____
(Physician's Signature)
Today's Date: _____

** **Symptoms**
Chest tightness, cough, shortness of breath
Tightness in throat, difficulty swallowing
Swelling of lips, tongue, throat
Itching mouth
Hives or hoarseness
Stomach cramps, vomiting or diarrhea
Dizziness or faintness