

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**

