Participant's Name: _____ D.O.B _____ Gender: _____

Allergic to: _____

EpiPen: Yes ☐ No ☐

Give Checked Medication**

(To be determined by a physician authorizing treatment)

Symptoms:

•	If a food allergen has been ingested, but no symptoms	☐ Epinephrine	☐ Antihistamine
•	Mouth — Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
•	Skin — Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
•	Gut — Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
•	Throat* — Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
•	Lung* — Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
•	Heart* — Weak, thready pulse, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
•	Other _____	☐ Epinephrine	☐ Antihistamine
•	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

*The severity of symptoms can change quickly, *Potentially life-threatening

DOSAGE

Epinephrine: inject intramuscularly ☐ EpiPen ® ☐ EpiPen ® Jr. ☐ Twinject ™ 0.3 mg ☐ Twinject ™ 0.15 mg

Other: _____

Antihistamine: give _____

(Medication/dose/route)

****Cain Center for the Arts must have any/all medications on site, in original container fully labeled, with child's name clearly indicated****

Other instructions / directions: _____

STEP 2: EMERGENCY CALLS

1) Call 911. State that an allergic reaction has been treated and additional epinephrine or antihistamine may be needed.
2) Dr. _____ at _____ Phone: _____
3) Emergency Contacts (*other than Primary Guardian(s)):*

Name / Relationship _____ Phone: _____

Name / Relationship _____ Phone: _____

Name / Relationship _____ Phone: _____

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

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____