

Medical Action Plan for Wake Forest Presbyterian Church

Child's Name: _____ Age: _____

Date of Birth: _____ Class: _____

Allergy to/Medical concern: _____

Symptoms/Treatments

(In this area, please be specific as to the steps you would like for us to take with your child in the event of a medical emergency involving his/her medical concern listed above.)

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

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

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen Jr., Twinject 0.3mg, Twinject 0.15mg
(see reversed side for instructions)

Antihistamine: give _____
(medication/dose/route)

Other: give _____
(medication/dose/route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Place picture of child here

EMERGENCY CALLS

1. Call 911. Give the operator the information of an allergic reaction and request an ambulance. Church address: 12605 Capital Blvd, Wake Forest, NC 27587—
Ph.#: 556-7777(church) or 488-1820(preschool)

2. Dr. _____ Phone#: _____

3. Parent _____ Phone #: _____

4. Emergency Contacts: _____ Phone Numbers: _____
Name/Relationship

a. _____ 1. _____

b. _____ 1. _____

IF PARENT/GUARDIAN CANNOT BE REACHED, CHILD WILL BE TRANSPORTED WITH THE TEACHER TO THE
HOSPITAL OF CHOICE: _____
(Hospital's name)

Parent/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____
(Required)