



Authorization for Emergency Care of Children with Severe Allergies

Child's Name: _____ Birthdate: _____ Dates Valid: _____

Please have your child's physician complete the following. Use a separate form for each allergen.

Allergens: List what events and/or substances may trigger a severe allergic reaction.

Symptoms: Provide a complete list of symptoms that indicate a child has come into contact with an allergen and that he or she requires emergency treatment.

_____ Shortness of breath or difficulty breathing

_____ Swelling of the face and/or lips

_____ Hives

_____ Vomiting

_____ Diarrhea

_____ Other _____

Procedures: Indicate necessary steps in the order they should be taken.

_____ Give Benadryl: _____ mL orally when the child shows (list symptoms) _____

_____ Administer EpiPen Jr. and/ or inhaler when the child shows (list symptoms) _____

_____ *****List specific, step by step instructions for administration of EpiPen and/or inhaler (more detailed than "Give as directed"). _____

_____ Call 911 _____ Call parent(s)/guardian(s). List ALL possible contact numbers in the order we should try calling, indicating home/cell and mom/dad/relative _____

_____ Other _____

Child's Physician: _____

Address: _____ Phone #: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____

Parent Signature: _____ Date: _____