LEHIGH CAREER & TECHNICAL INSTITUTE
ANAPHYLAXIS EMERGENCY CARE PLAN (ECP)

Patient Name: ________________________________________  DOB: _____________

Allergies: _________________________________________________

Asthma  □ Yes (high risk for severe reaction)  □ No

Additional health problems besides anaphylaxis: ________________________

Concurrent medications: _____________________________________________

Symptoms of Anaphylaxis

MOUTH       Itching, swelling of the lips, and/or tongue
THROAT*     Itching, tightness/closure, hoarseness
SKIN        Itching, hives, redness, swelling
GUT         Vomiting, diarrhea, cramps
LUNG*       Shortness of breath, cough, wheeze
HEART*      Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.
*Some symptoms can be life-threatening. ACT FAST!

Emergency Action Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (initial):
   □ Adrenaclick (0.15 mg)  □ Adrenaclick (0.3 mg)
   □ Auvi-Q (0.15 mg)    □ Auvi-Q (0.3 mg)
   □ EpiPen Jr. (0.15 mg) □ EpiPen (0.3 mg)
   □ Epinephrine Injection, USP Auto-injector-authorized generic
     (0.15 mg)  □ Epinephrine Injection, USP Auto-injector-authorized generic
                 (0.3 mg)
   □ Other (0.15 mg)    □ Other (0.3 mg)

Specify others: ________________________________

FOLLOW MEDICAL EMERGENCY PROCEDURE – SEVERE ALLERGY/ EPIPEN – CODE 1 EPIPEN. IF ON A
FIELD TRIP OR NOT ON LCTI SCHOOL GROUNDS – CALL 9-1-1.

Emergency Contact #1:  Home _______________  Work _______________  Cell _______________

Emergency Contact #2:  Home _______________  Work _______________  Cell _______________

Emergency Contact #3:  Home _______________  Work _______________  Cell _______________

Comments: ____________________________________________________________________________

_____________________________________________________________________________________

Health Care Provider Signature/Date/Phone Number

_____________________________________________________________________________________

Parent’s Signature/Date

_____________________________________________________________________________________

Health Room Officer Signature/Date

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