

**Dor Hadash Early Childhood Educational Center  
AUTHORIZATION FOR EMERGENCY TREATMENT  
for possible Life Threatening Allergies**

Completed & Signed by Parents and Physicians

Student's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Allergic to: \_\_\_\_\_

1. If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows:

**Symptoms Give Medication checked "X"**

**Mouth:** Itching, tingling, or swelling of lips, tongue, mouth      ( ) Benadryl ( ) EpiPen

**Skin:** Hives, swelling on face or extremities, itchy rash      ( ) Benadryl ( ) EpiPen

**Gut:** Nausea, abdominal cramps, vomiting, diarrhea      ( ) Benadryl ( ) EpiPen

**Throat:** Tightening of throat, hoarseness, hacking cough      ( ) Benadryl ( ) EpiPen

**Lung:** Shortness of breath, repetitive coughing, wheezing      ( ) Benadryl ( ) EpiPen

**Heart:** Thready pulse, passing out, fainting, pale, blueness      ( ) Benadryl ( ) EpiPen

**General:** Panic, sudden fatigue, chills, fear of impending doom ( ) Benadryl ( ) EpiPen

If a food allergen has been ingested, but no symptoms ( ) Benadryl ( ) EpiPen

If a reaction is progressing (several of the above areas affected) ( ) Benadryl ( ) EpiPen.

Medication Doses:

**Antihistamine (liquid Diphenhydramine, Benadryl):**

Give \_\_\_\_\_ Teaspoon(s), \_\_\_\_\_ cc ( \_\_\_\_\_ mg) by mouth.

**Epinephrine**

EpiPen [EpiPen \_\_\_\_\_ ( \_\_\_\_\_ mg)] injected once into upper outer thigh

Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

Call 911 (or Ambulance service and phone number: \_\_\_\_\_)

State that the child had a severe allergic reaction, and additional epinephrine does may be needed.

Additional contact information:

Allergist Name \_\_\_\_\_ Phone \_\_\_\_\_

Pediatrician Name \_\_\_\_\_ Phone \_\_\_\_\_

**Parent Name (other contacts) and Contact Numbers:**

Name \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2)

\_\_\_\_\_

Name \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2)

\_\_\_\_\_

Other allergies, medication allergies, medical conditions \_\_\_\_\_ Approximate weight \_\_\_\_\_  
lbs

**DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL  
FACILITY EVEN IF PARENTS CANNOT BE REACHED!**

\_\_\_\_\_

\_\_\_\_\_  
Parent Signature / Date Physician's Signature / Date