

Form 1350-10C

Approved: 25-Oct-2016

Child's Name: _____

Date of Birth: _____

Parent/Guardian: _____

Home Phone No. _____

Physician: _____

Work Phone No. _____

Physician Phone No. _____

MY CHILD'S ANAPHYLAXIS TRIGGERS ARE:

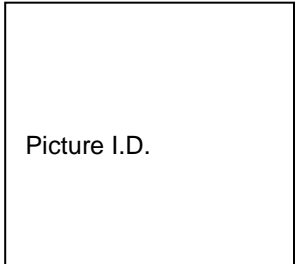
Peanuts Nuts Milk All Dairy Eggs Shellfish Fish

Food Additives (list) _____

Insect Stings (list) _____

Medications (list) _____

Others (lis) _____



Picture I.D.

MY CHILD'S ANAPHYLAXIS SYMPTOMS ARE USUALLY:

Swelling (eyes, lips, face, tongue)

Vomiting

Difficulty breathing or swallowing

Coughing or choking

Cold, clammy, sweaty skin

Stomach cramps, diarrhea

Flushed face or body

Dizziness, confusion

Fainting or loss of consciousness

Changes of voice

Others (list) _____

MY CHILD'S EMERGENCY TREATMENT IS:

Medication is kept/stored (where?) _____

Anti-histamine (specify brand/dosage) _____

Epi-Pen Ana-Kit (specify dosage) _____

Call 911 and tell the dispatcher that a child is having a life-threatening anaphylactic reaction.

Call the parent or guardian.

Parent/Guardian Signature: _____

Date Completed: _____

Reviewed By: _____

Date Completed: _____

The information collected on this form is subject to and protected by the provision of the Freedom of Information and Protection of Privacy Act.