

ALLERGIC REACTION / ANAPHYLAXIS RECORD

Facility Name _____ Date _____

Resident Information:

Name: _____

DOB ____ / ____ / ____ AGE ____

Estimated/Actual Weight _____ lbs./kg

Event which preceded reaction:

_____ Immunization

_____ Medication administered

_____ Biologicals administered

_____ Other: (please explain) _____

TIME OF REACTION: _____ AM / PM

TIME EMS CALLED: _____ AM / PM

Signs and Symptoms: (please check)

_____ Apprehension

_____ Flushing and/or skin edema

_____ Palpitations

_____ Numbness and tingling

_____ Itching

_____ Localized or generalized urticaria

_____ (rash, welts)

_____ Seizure Activity

_____ Choking sensation

_____ Coughing/hoarseness/wheezing

_____ Difficulty breathing

_____ Nausea and vomiting

_____ Severe hypotension

_____ Vasomotor collapse

_____ Loss of consciousness

Other (e.g., dizziness): _____

OTHER OBSERVATIONS / COMMENTS: _____

SIGNATURE OF Nurse

DISPOSITION: _____

REVIEWER: _____

NOTE: Send copies of both pages of this record with resident referred to a physician's office or hospital

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.

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1. Call for HELP.
Assign timekeeper/recorder.
TIME EMS CALLED: _____ AM/PM
TIME EMS ARRIVED: _____ AM/PM
TIME EMS DEPARTED TO HOSPITAL: _____ AM/PM
Hospital's Name: _____

2. Assure AIRWAY.
Check VITAL SIGNS q 5 minutes.
CPR if necessary.

VITAL SIGNS (monitor every 5 minutes)

Time	B/P	Pulse	Resp
_____	____/____	_____	_____
_____	____/____	_____	_____
_____	____/____	_____	_____
_____	____/____	_____	_____
_____	____/____	_____	_____
_____	____/____	_____	_____
_____	____/____	_____	_____

CPR Indicated: _____ YES _____ NO
TIME CPR started: _____ AM / PM
TIME CPR ended: _____ AM / PM

Physician Notification

Assign timekeeper/recorder.
TIME PHYSICIAN CALLED: _____ AM/PM
TIME PHYSICIAN RESPONDED: _____ AM/PM
TREATMENT Orders: _____

Medication Administration

Med Name: _____

TIME	DOSE	ROUTE
_____	_____	_____
_____	_____	_____
_____	_____	_____

EpiPen® Auto-Injector

TIME Administered: _____ AM/PM
TIME Administered: _____ AM/PM
TIME Administered: _____ AM/PM

Twinject 0.3 mg/0.3 mL _____ AM/PM
Twinject 0.3 mg/0.3 mL _____ AM/PM
Twinject 0.3 mg/0.3 mL _____ AM/PM

Adrenaclick 0.3 mg/0.3 mL _____ AM/PM
Adrenaclick 0.3 mg/0.3 mL _____ AM/PM
Adrenaclick 0.3 mg/0.3 mL _____ AM/PM

Auvi-Q 0.3 mg/0.3 mL _____ AM/PM
Auvi-Q 0.3 mg/0.3 mL _____ AM/PM
Auvi-Q 0.3 mg/0.3 mL _____ AM/PM

Other, please specify name, dosage and time administered: _____

Additional Notes:

