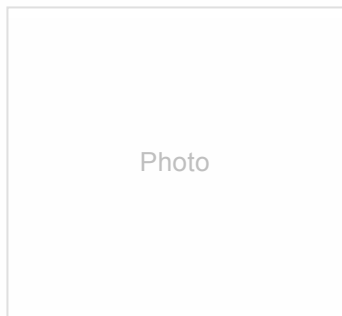


## THIS CHILD HAS THE FOLLOWING ALLERGIES:

Name:

DOB:



Photo

Emergency contact details:

1)



2)



Child's  
Weight:                      Kg

### Mild-moderate allergic reaction:

- Swollen lips, face or eyes
- Itchy / tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

### ACTION:

- Stay with the child, call for help if necessary
- Give antihistamine:
- Contact parent/carer (if vomited, can repeat dose)

## Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction):

- AIRWAY:** Persistent cough, hoarse voice, difficulty swallowing, swollen tongue
- BREATHING:** Difficult or noisy breathing, wheeze or persistent cough
- CONSCIOUSNESS:** Persistent dizziness / pale or floppy suddenly sleepy, collapse, unconscious

### If ANY ONE of these signs are present:

1. **Lie child flat.** If breathing is difficult, allow to sit
2. **Give EpiPen® or EpiPen® Junior**
3. **Dial 999 for an ambulance\*** and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

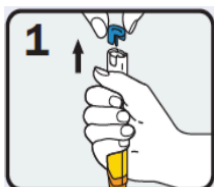
**If in doubt, give EpiPen®**

### After giving EpiPen:

1. Stay with child, contact parent/carer
2. Commence CPR if there are no signs of life
3. If no improvement **after 5 minutes**, give a further EpiPen® or alternative adrenaline autoinjector device, if available

\*You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

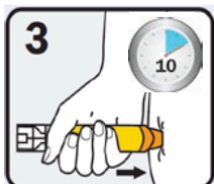
### How to give EpiPen®



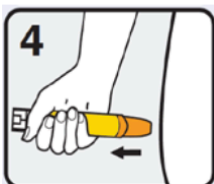
Form fist around EpiPen® and PULL OFF BLUE SAFETY CAP



SWING AND PUSH ORANGE TIP against outer thigh (with or without clothing) until a click is heard



HOLD FIRMLY in place for 10 seconds



REMOVE EpiPen®. Massage injection site for 10 seconds

### Additional instructions:

Keep your EpiPen device(s) at room temperature, do not refrigerate.

For more information and to register for a free reminder alert service, go to [www.epipen.co.uk](http://www.epipen.co.uk)

Produced in conjunction with:



This is a medical document that can only be completed by the patient's treating health professional and cannot be altered without their permission.

This plan has been prepared by: \_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_



Date: \_\_\_\_\_