

ASSOCIATED ALLERGISTS AND ASTHMA SPECIALISTS

RESCUE MEDICATION FORM

Name _____ DOB _____ DATE _____

This patient has been diagnosed with: (Circle)

ASTHMA FOOD ALLERGIES ENVIRONMENTAL ALLERGIES INSECT STING ALLERGIES

The following rescue medications have been prescribed: (Check all that apply)

____ ALBUTEROL* (Pro Air, Proventil, Ventolin, Xopenex, Maxair, Combivent)

Dosage/Indication: 2 puffs every 4-6 hours as needed for wheezing, coughing, chest tightness, difficulty breathing or shortness of breath.

Side effects may include shakiness and hyperactivity.

____ May Self-Administer ____ Requires Supervision

____ Must use with Spacer (1 puff, breathe in deeply. Hold for 10 seconds. Repeat with 2nd puff).

***SEE ASTHMA ACTION PLAN**

____ EPINEPHRINE** (Epi-Pen, Epi-Pen Jr., Twinject, Twinject Jr.) ____ May Self-Administer

Dosage/Indication: 1 intramuscular injection into thigh to treat symptoms of severe allergic reactions including swelling of the face, throat or mouth and shortness of breath. CALL 911. 2nd dose may be given after 10-15 minutes if symptoms recur.

Side effects may include paleness, shakiness, increased heart rate, nausea.

****SEE FOOD ALLERGY ACTION PLAN**

____ BENADRYL** _____(dose) -or ____ (other antihistamine)_____ (dose)**

Dosage/Indication: Dose is weight dependent. To be given for hives, itchy rash, runny nose and mild to moderate allergic symptoms.

Side effects may include fatigue and dry mouth.

****SEE FOOD ALLERGY ACTION PLAN**

MD Signature _____ Phone _____

Stamp: _____ Date _____