

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES

**INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY ACTION CARD**

PHOTO OF CHILD (Optional)	CHILD'S FULL NAME:		DATE OF BIRTH: / /	GENDER:	
	KNOWN ALLERGENS:			ASTHMA? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				HISTORY OF ANAPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	

POTENTIAL SYMPTOMS:	MEDICATION/DOSAGE/LOCATION:
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EXPOSURE ACTION PLAN	1.	
	2.	
	3.	
	4.	

RISK MANAGEMENT STRATEGIES:

NOTES:

EMERGENCY CONTACT(S):

PROVIDER SIGNATURE: X	DATE: / /
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SIGNATURE – PARENT OR PERSON LEGALLY RESPONSIBLE: X	DATE: / /
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