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SYSTEMIC REACTION - TREATMENT RECORD FORM

Identifying Information:

Patient Name: _____ Date of Birth: _____

Prescribing Physician: _____ Treating Physician: _____

Disorders (asthma?): _____

Injection Record:

Date & Time of Injection: _____ Date & Time of Reaction: _____

Type of shot received with location: _____

Maintenance or Build-up: _____ Prior Systemic Reaction: _____

Possible Signs and Symptoms (circle if present):

Respiratory	**Skin**	**Eyes/Nasal**	**Vascular**	**Other**
Shortness of Breath	Hives	Runny Nose	Hypotension	Difficulty Swallowing
Wheezing	Angioedema	Red Eyes	Chest Discomfort	Abdominal pain
Cough	Generalized Itch	Congestion	Dizzyness	Nausea/Vomiting
Stridor	Flushing	Sneezing	Headache	Diaphoresis

Time	Symptom	Vitals: Pulse/Sat/BP/PEFR	Intervention

Post Reaction Treament:

EMS Activated?: _____ Condition on Discharge: _____

Impression: _____ Time Discharged: _____

Comments: _____

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