Allergy Action Plan

Camper
Name: ___________________________ D.O.B: __________ Session: ___ Cabin: ________________

ALLERGY TO:

□ Yes* □ No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: ________________________________________________________________

☐ If a food allergen has been ingested, but no symptoms: ☐ Epinephrine ☐ Antihistamine
☐ Mouth Itching, tingling, or swelling of lips, tongue, mouth ☐ Epinephrine ☐ Antihistamine
☐ Skin Hives, itchy rash, swelling of the face or extremities ☐ Epinephrine ☐ Antihistamine
☐ Gut Nausea, abdominal cramps, vomiting, diarrhea ☐ Epinephrine ☐ Antihistamine
☐ Throat† Tightening of throat, hoarseness, hacking cough ☐ Epinephrine ☐ Antihistamine
☐ Lung† Shortness of breath, repetitive coughing, wheezing ☐ Epinephrine ☐ Antihistamine
☐ Heart† Thready pulse, low blood pressure, fainting, pale, blueness ☐ Epinephrine ☐ Antihistamine
☐ Other† _____________________________________________________________________

☐ If reaction is progressing (several of the above areas affected), give ☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give __________________________________________

medication/dose/route

Other: give __________________________________________

medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: __________________________ ). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. __________________________ PhoneNumber: ____________ at ________________

3. Emergency contacts:

Name/Relationship Phone Number(s)

a. __________________________ 1.) __________________________ 2.) __________________________

b. __________________________ 1.) __________________________ 2.) __________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature __________________________ Date __________________________

Doctor’s Signature __________________________ Date __________________________

(Required)