Allergy Action Plan

Camper Name:_____D.O.B:_____Session:_____Cabin:_____

ALLERGY TO:_____

Asthmatic ☐ Yes* ☐ No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication**:** (**To be determined by physician authorizing treatment)
☐ 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† _____	☐ Epinephrine ☐ Antihistamine
☐ 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)