



Allergy Action Plan (print, fill out and send a copy with the medication)

Camper's Name: _____ D.O.B: _____

ALLERGY TO: _____

Asthmatic: *Yes No * higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

- If a food allergen has been ingested, but no symptoms
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat + Tightness if throat, hoarseness, hacking cough
- Lung + Shortness of breath, repetitive coughing, wheezing
- Heart+ Thready pulse, low blood pressure, fainting, pale, blueness
- Other + _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication **:

(To be determined by physician authorizing treatment)

- | | | |
|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Other |

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

**DRUG/DOSAGE

Epinephrine: inject intramuscularly (**circle one**): EpiPen® 0.15 mg /0.3mg Auvi-Q®: 0.15 mg/0.3mg
Twinject™ 0.15mg/0.3mg

Antihistamine: medication/dose/route

give Drug Name: _____ Dose:(mg) _____ Repeat Every: _____

Other: medication/dose/route

give Drug Name: _____ Dose:(mg) _____ Repeat Every: _____

STEP 2: EMERGENCY CALLS

1. Call 911 State that an allergic reaction has been treated and additional epinephrine may be needed.
2. 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 _____