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:	**Give Checked Medication **:** (To be determined by physician authorizing treatment)
• If a food allergen has been ingested, but no symptoms	☐ Epinephrine ☐ Antihistamine ☐ Other
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine ☐ Other
• Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine ☐ Other
• Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine ☐ Other
• Throat + Tightness if throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine ☐ Other
• Lung + Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine ☐ Other
• Heart+ Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine ☐ Other
• Other + _____	☐ Epinephrine ☐ Antihistamine ☐ Other
• If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine ☐ 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 _____ MD Stamp:

Doctor's Signature _____ Date _____