

MEDICATION AND ALLERGY ACTION PLAN FORM

TO BE COMPLETED BY PHYSICIAN AND PARENT. THIS FORM TO BE USED FOR CHILDREN WITH SEVERE ALLERGIES ONLY.

ALLERGY TO: _____

Camper's Name _____ D.O.B. _____ Division/Group _____

Asthmatic Yes* _____ No _____ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

SYSTEMS: SYMPTOMS:

MOUTH	Itching and swelling of the lips, tongue, or mouth
THROAT*	Itching and/or sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG*	Shortness of breath, repetitive coughing, and/or wheezing
HEART*	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

(BELOW IS TO BE FILLED OUT AND SIGNED BY YOUR CHILD'S PHYSICIAN)

ACTION FOR MINOR REACTION

1. If only symptom(s) are _____ give _____ medication/dose/route

Then call:

2. Mother _____ Phone/Cell _____
3. Father _____ Phone/Cell _____
4. Or Emergency contacts
5. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion is suspected and/or symptom(s) are: _____, give _____ **IMMEDIATELY!**
_____ medication/dose/route

Then Call:

2. **Rescue Squad** (ask for advanced life support)
3. Mother _____ Phone/Cell _____
4. Father _____ Phone/Cell _____
5. Or Emergency contacts
6. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent Signature _____ Date _____

Physician's Signature _____ Date _____

Physician's Name, Address, Phone (Please Print) _____