

# 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:

<b>MOUTH</b>	Itching and swelling of the lips, tongue, or mouth
<b>THROAT*</b>	Itching and/or sense of tightness in the throat, hoarseness, and hacking cough
<b>SKIN</b>	Hives, itchy rash, and/or swelling about the face or extremities
<b>GUT</b>	Nausea, abdominal cramps, vomiting, and/or diarrhea
<b>LUNG*</b>	Shortness of breath, repetitive coughing, and/or wheezing
<b>HEART*</b>	"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) \_\_\_\_\_

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