Allergy Action Plan

Camper's Name: _____ Date of Birth: _____

Allergy To: _____

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

* Step 1: Treatment *

Symptoms:	**Give Circled Medication **:** (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 ** Weak pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
• Other **	Epinephrine	Antihistamine
• If reaction is progressing (several of the above area affected), give:	Epinephrine	Antihistamine

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

Dosage

Epinephrine: (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

* Step 2: Emergency Calls *

1.) Physician _____ Phone number: _____

2.) Parent/Guardian _____ Phone number: _____

3.) Alt. Emergency Contact: _____ Phone number: _____

IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO HOSPITAL

Parent/Guardian Signature _____ Date: _____

Doctor's Signature _____ Date: _____
Required