

ALLERGY ACTION PLAN

Camper Name: _____ Date of Birth: _____

Allergies: _____

Previous episode of anaphylaxis: Yes No

If yes, please explain: _____

History of asthma: Yes No

Symptoms	Give Checked Medication	
If a food has been ingested (or student stung by insect if order is for insect sting allergy) but no symptoms:	___ Epinephrine	___ Antihistamine
Mouth (itching, tingling or swelling of lips, tongue, mouth)	___ Epinephrine	___ Antihistamine
Skin (hives, itchy rash, swelling of face or extremities)	___ Epinephrine	___ Antihistamine
Gut (nausea, vomiting)	___ Epinephrine	___ Antihistamine
Throat (Tightening of throat, hoarseness, hacking cough)	___ Epinephrine	___ Antihistamine
Lung (Shortness of breath, repetitive coughing, wheezing)	___ Epinephrine	___ Antihistamine
Heart (thready pulse, low BP, fainting, pale, blueness)	___ Epinephrine	___ Antihistamine
If reaction is progressing (2 or more body systems involved)	___ Epinephrine	___ Antihistamine
Other:	___ Epinephrine	___ Antihistamine

Benedryl / Antihistamine Dose _____

Epinephrine Auto-injector: EpiPen EpiPen Junior

Choose one administration order:

- Give Epinephrine only. (Delegate will be assigned to administer epinephrine in absence of nurse)
- Give Antihistamine and Epinephrine at the same time.
- Give Antihistamine first, observe for further symptoms and give epinephrine if symptoms don't improve.

PLEASE NOTE: IN THE ABSENCE OF THE CAMP NURSE, ANY ANTIHISTAMINE ORDER WILL BE DISREGARDED AND A TRAINED DELEGATE WILL GIVE THE AUTO-INJECTABLE DOSE OF EPINEPHRINE.

- This camper has been trained and is capable of self-administration of the medication named above.
- This camper carries an EpiPen on their person.

Physician Stamp

Physician Signature & Date



PARENTS/GUARDIANS:

A twin pack Epinephrine auto-injector must be provided to the school for your child’s use. Antihistamines and epinephrine must be brought to school by an adult before the first day of school and must be provided in the original labeled pharmacy container. Please check that the medication provided is current and not expired.

Please sign and date the following:

I verify that my child, _____, has a potentially life-threatening illness. I hereby give permission for the school nurse to administer Epinephrine to my child as prescribed by my child’s physician. I request that a delegate be trained to administer Epinephrine to my child, and I give the delegate permission to administer Epinephrine to my child as prescribed by my child’s physician. I further acknowledge that The Willow School incur no liability as a result of any injury arising from administration of this medication to my child and shall indemnify and hold harmless The Willow School and its employees or agents against any claims arising out of administration of this medication to my child.

Parent/Guardian Signature Date

Mom cell: _____ Mom Home: _____

Dad Cell: _____ Dad Home: _____

Emergency Contact: _____