EMERGENCY TREATMENT PLAN FOR ALLERGIC REACTIONS AND ACUTE RESPIRATORY DISTRESS AND THE PERMISSION TO ADMINISTER MEDICATIONS BY CAMP PERSONNEL

_____ Food Allergy _____ Asthma _____ Bee/Wasp Stings _____ Other

Patient's Name: _____ DOB: _____

Physician's Name: _____ Phone Number: _____

Specific Allergy: _____

If the patient thinks he/she has been exposed to the above named allergen:

_____ Observe patient for symptoms of anaphylaxis X 2 hours

_____ Administer Epinephrine before symptoms occur, IM: _____ EPIPEN Adult _____ EPIPEN JR

_____ Administer Epinephrine if symptoms occur, IM: _____ EPIPEN Adult _____ EPIPEN JR

_____ Administer Benadryl per appropriate age/weight dose

_____ Call 911, transport to ER

If the patient is experiencing respiratory distress (shortness of breath, wheezing, coughing):

_____ Administer _____ PUFFS of _____ INHALER, REPEAT _____

_____ Call 911, transport to ER

Side effects, if any, to be observed: _____

CAMPER IS TO CARRY & MAY SELF-ADMINISTER EPIPEN / INHALER WHILE AT CAMP:

_____ Yes _____ No

Physician's Stamp:

Physician's Signature: _____ Date: _____

- I REQUEST THAT MEDICATION BE ADMINISTERED TO MY CHILD AS DIRECTED AND DESCRIBED ABOVE BY CAMP PERSONNEL AND GIVE PERMISSION FOR THE EXCHANGE OF INFORMATION BETWEEN THE PRESCRIBER AND CAMP NURSE AS NECESSARY TO ENSURE THE SAFE ADMINISTRATION OF THIS MEDICATION. I UNDERSTAND I MUST SUPPLY THE CAMP WITH THE NECESSARY MEDICATION.
- IF APPROVED BY THE PHYSICIAN ABOVE, I REQUEST AND GIVE MY PERMISSION FOR MY CHILD TO CARRY AND SELF ADMINISTER THE MEDICATION.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

Parent/Guardian's Address: _____ Town/State: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____