INSECT/LATEX ALLERGY ACTION PLAN FOR WINNEWALD DAY CAMP

Name: _____ DOB: _____ GROUP: _____

ALLERGIC TO: _____

_____

***ASTHMATIC** **_____YES** **_____ NO** *****Higher risk for severe reactions

PLACE CHILD'S PICTURE HERE

HCP = Health Care Provider

◆STEP 1: TREATMENT◆

SYMPTOMS		**Give Checked Medication**:** ****(To be determined by HCP authorizing treatment)**	
☐If child has touched latex but *no symptoms:*		☐epinephrine	☐antihistamine
☐If child has been stung by **INSECT KNOWN** to cause allergic reactions but *no symptoms:*		☐epinephrine	☐antihistamine
►If child has been stung by **UNKNOWN INSECT** 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 or thready pulse, low blood pressure, fainting, pale, blueness	☐epinephrine	☐antihistamine
►Other	◆_____	☐epinephrine	☐antihistamine
►If reaction is progressing (several of the above areas affected), **GIVE**		☐epinephrine	☐antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen ® Jr Twinject® 0.3 mg Twinject® 0.15mg

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆STEP 2: EMERGENCY CALLS◆

1. Call 911 (or rescue squad _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent: _____ Phone Number(s): _____

4. Emergency contacts: _____ Phone Numbers: _____
name/relationship

_____

EVEN IF PARENT.GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____
(Required)