SEVERE ALLERGY ACTION PLAN FOR WINNEWALD DAY CAMP

NAME: ____DOB: ____________ GROUP: _________

ALLERGIC TO: ____

Does Camper Also React To Allergen Through TOUCH or SMELL?

How Is This Treated?____

*Asthmatic ___ YES ___ NO *Higher Risk For Severe Reactions

Antihistamine Name: ____ DOSE: ___________________

LIQUID LINGUAL MELTS TABLET OR CAPSULE

Allergen-Free Table Requested Can Sit At End Of Regular Table

STEP 1 - TREATMENT

SYMPTOMS		
If Allergen Is *Suspected* Of Being Injected (Insect Sting) Or Ingested But No Symptoms, Give	**EPINEPHRINE**	**ANTIHISTAMINE**
If Allergen Has Been Injected (Insect Sting) Or Ingested But No Symptoms, Give	**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, thread pulse, low blood pressure, fainting, pale, blueness	**EPINEPHRINE**	**ANTIHISTAMINE**
OTHER		**EPINEPHRINE**	**ANTIHISTAMINE**
IF ASTHMATIC	Give rescue inhaler _______________ as prescribed **AFTER EPINEPHRINE.**	**EPINEPHRINE**	**ANTIHISTAMINE**

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

If Reaction Is Progressing Or Several Systems Are Affected Give	**EPINEPHRINE**	**ANTIHISTAMINE**
IF NO IMPROVEMENT WITHIN __________ MINS, GIVE	☐ **EPINEPHRINE**	☐**ANTIHISTAMINE**

☐ **Lay person flat, raise legs & keep warm. If breathing is difficult or if vomiting, sit up or lie on side. *BE PREPARED TO PERFORM CPR IF NECESSARY*.**

DOSAGE /TYPE OF EPINEPHRINE DELIVERY: Epi-Pen 0.3mg Epi-Pen JR 0.15mg Auvi Q 0.3 mg AuviQ 0.15mg

OTHER: ____

***DELEGATE APPROVED:** ____ **DATE:** ______________

(Parent Signature)

***Winnewald Day Camp Delegate Approval Release must also be signed. See Web site for this form.**

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EMERGENCY CONTACTS (PLEASE DO NOT LEAVE ANY BLANKS)

Camper's Name: ____DOB: ________________________

1. CALL 911 (or local rescue squad at (   ) ________________________) reporting that an allergic reaction has been treated and additional epinephrine might be needed.

2. CALL CAMP; Camp Director Will Contact Parents.

3. Dr. ______________________________________Phone Number: ________________________________

4. Parent: __________________________________ 1st Phone # to call: ____________________________
   2nd Phone # to call: ________________________ 3rd Phone # to call:____________________________

5. Parent: __________________________________ 1st Phone # to call: ____________________________
   2nd Phone # to call: ________________________ 3rd Phone # to call: ____________________________

6. Emergency Contacts:

   Name: _______________________________________Relationship: ______________________________
   1st # to call: ____________________________ 2nd # to call: ______________________________________
   3rd # to call: ______________________________
   Name: _______________________________________Relationship: ______________________________
   1st # to call: ____________________________ 2nd # to call: ______________________________________
   3rd # to call: ______________________________
   Name: _______________________________________Relationship: ______________________________
   1st # to call: ____________________________ 2nd # to call: ______________________________________
   3rd # to call: ________________________

Even If Parent/Guardian Cannot Be Reached, Do Not Hesitate To Call 911,
Medicate & Transport Child To Medical Facility.

Parent/Guardian Signature: ______________________________________ Date: __________________________

Health Care Provider's Signature: __________________________________ Date: __________________________

STAFF MEMBERS TRAINED IN EPINEPHRINE ADMINISTRATION:

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