



Pine Valley Day Camp Non-Food Allergy Action Plan

TO THE PHYSICIAN: Please complete **Physician's Medication Order Form** section of this form for the child below. It includes treatment and medication information for non-food allergies (such as bee stings) for this child who is either enrolled as a camper or is a volunteer Junior Counselor in our summer day camp program

TO THE PARENTS: Please attach child's picture (right) and complete **Page 2** of this form and send the completed 2-page Allergy Action Plan to our office *prior to camp*.

Camper's Name: _____ Birth Date: ____ / ____ / ____

ALLERGY TO: _____

**Place Child's
Picture Here**

PHYSICIAN'S MEDICATION ORDER FORM

Asthmatic: Yes* ___ No ___ *Higher risk for severe reaction

Symptoms:

Give Checked Medication:**
(To be determined by physician authorizing treatment)

- If an allergen has been introduced, but *no symptoms*: Epinephrine Antihistamine
- Mouth Itching, tingling, or swelling of the 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 the throat, hoarseness, hacking cough Epinephrine Antihistamine
- Lung † Shortness of breath, repetitive coughing, wheezing Epinephrine Antihistamine
- Heart † 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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

Signature of Physician: _____ **Date:** _____

Pine Valley Day Camp (410) 668-9888 fax(410) 663-3654

PARENTS: PLEASE COMPLETE PAGE 2

□ EMERGENCY CALLS AND OTHER INFORMATION □

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. at _____
List location and contact information

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1. _____	2. _____
b. _____	1. _____	2. _____
c. _____	1. _____	2. _____

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

Parents: Please provide any additional information or instructions on a separate piece of paper.

Parent/Guardian Signature _____ Date _____

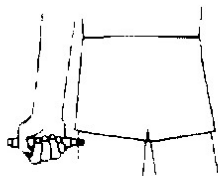
EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



Once EpiPen® is used, call 911. Take the used unit with you to the Emergency Room.

- Hold black tip near outer thigh (always apply to thigh).



For children with multiple allergies, consider providing separate Action Plans for each allergen.

- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.