

**ALLERGY TREATMENT PLAN AND PERMISSION
FOR THE ADMINISTRATION OF MEDICATIONS
BY CAMP PERSONNEL**

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ TELEPHONE: _____

PHYSICIAN'S NAME: _____ PATIENT'S PCP: _____

PHYSICIAN'S ADDRESS: _____ TELEPHONE: _____

ASTHMA: ____ YES ____ NO

SPECIFIC ALLERGY: _____

IF PATIENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:

_____ Observe patient for symptoms of anaphylaxis ** x 2 hours

_____ Administer **adrenaline** before symptoms occur, IM _____ Epipen Jr. Adult

_____ Administer **adrenaline** if symptoms occur, IM _____ Epipen Jr. Adult

_____ Administer Benadryl _____ tsp. or Atarax _____ tsp. Swish & Swallow

_____ Administer _____

_____ Call 911, transport to ER if symptoms occur, for evaluation, treatment and observation x 4 hours

IF REACTION OCCURS,
PLEASE NOTIFY THIS OFFICE!

Physician's Signature

Today's Date

1. Is this a controlled drug? ____ Yes ____ No

2. Medication shall be administered from _____ to _____
(dates)

3. Relevant side effects, if any, to be observed: _____

4. Please allow child to self-administer medication. ____ Yes ____ No

Signature _____ M.D.

****SYMPTOMS OF ANAPHYLAXIS**

Chest tightness, cough .
Shortness of breath, wheezing
Tightness in throat, difficulty swallowing
Hoarseness
Swelling of lips, tongue, throat
Itchy mouth, itchy skin .
Hives or swelling
Stomach cramps, vomiting or diarrhea
Dizziness or faintness

I HAVE RECEIVED, REVIEWED, AND UNDERSTAND THE ABOVE INFORMATION.

MY CHILD **MAY** CARRY AND SELF-ADMINISTER THE PRESCRIBED MEDICATION.

I AUTHORIZE CAMP STAFF TO CONTACT THE PRESCRIBING PHYSICIAN TO DISCUSS MY CHILD'S DIAGNOSIS, IF NEEDED.

Patient/Parent/Guardian Signature