KAA Attendee Allergy Action Plan

PLEASE COMPLETE THIS FORM ONLY IF THE ATTENDEE HAS AN ALLERGY CONCERN THAT COULD RESULT IN A REACTION AT CAMP.

Attendee's Name:_____ **D.O.B:**_____ **Group Leader** _____

ALLERGY TO (please provide a separate action plan for each allergen)_____

Please indicate if the attendee is Asthmatic □Yes □No If yes, an asthma action plan is required. *Higher risk for severe reaction.

STEP 1: TREATMENT

Symptoms:	**Give Checked Medication**** (Determined by attending physician or medical staff)
_ If a food allergen has been ingested, 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 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

Please note that the severity of symptoms can quickly change and become potentially life-threatening. It is important to continually monitor the attendee's symptoms until it is certain they are under control.

DOSAGE

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

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

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. Contact Emergency Contact (THIS MUST BE A PARENT/GUARDIAN IF THE ATTENDEE IS A CHILD)

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

I certify that the above information is correct to the best of my knowledge and that all necessary medications have been sent in quantities the entire camp visitation period as well as for any emergencies which may arise.

FOR THOSE UNDER 18: my opinion, my child □ should be allowed □ should **not** be allowed to carry and use his/her epi-pen by him/herself.

Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Adapted from The Food Allergy and Anaphylaxis Network