



# Food Allergy Action Plan

Place  
Child's  
Picture  
Here

\_\_\_\_\_ Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Camp Attending \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

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

### ◆STEP 1: TREATMENT◆

Symptoms:

- If a food allergen has been ingested, but no symptoms:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Thready pulse, low blood pressure, fainting, pale, blueness
- Other † \_\_\_\_\_

Give Checked Medication\*\*:

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. † Potentially life-threatening.  
\*\*Medication to be determined by physician authorizing treatment.

**NOTE: In accordance with Maryland State Regulations, the epinephrine auto-injector may be administered by unlicensed staff (Summer at Norwood employee) that are trained by the Health Director. Unlicensed staff are not allowed to wait for the appearance and observe for the development of symptoms for campers with an authorized prescriber's order to administer the epinephrine auto-injector.**

Dosage:

Epinephrine: inject intramuscularly (circle one)  
Epinephrine (0.15mg)    Epinephrine (0.3mg).

Location of EpiPen/EpiPen Jr. (nurse, child, classroom, etc.) \_\_\_\_\_

Antihistamine: give \_\_\_\_\_  
medication/dose/route

Other: give \_\_\_\_\_  
medication/dose/route

### ◆STEP 2: EMERGENCY CALLS◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency Contacts:

<u>Name/Relationship</u>	<u>Phone Numbers</u>
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 a medical facility!**

### ◆STEP 3: AUTHORIZATION◆

**Parent/Guardian Consent:** I have received, reviewed and understand the above information. I approve of this Allergy Action Plan. I give my permission for the camp nurse and trained camp personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I agree to release, indemnify, and hold harmless Summer at Norwood ("the camp") and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this camper. I assume full responsibility for providing the camp with the prescribed medications. I am aware that the injection may be administered by a trained, unlicensed staff member. I give my permission for the camp to share the above information with camp staff that need to know about my child's condition. I understand that the rescue squad (911) will always be called when an epinephrine auto-injector is administered, whether or not the student manifests any symptoms of anaphylaxis.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
I confirm my child is capable to safely carry and properly administer above medication  Yes  No

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I confirm student is capable to safely carry and properly administer above medication  Yes  No