

# EMERGENCY TREATMENT PLAN FOR ALLERGIC REACTIONS AND ACUTE RESPIRATORY DISTRESS AND THE PERMISSION TO ADMINISTER MEDICATIONS BY CAMP PERSONNEL

Food Allergy     Asthma     Bee/Wasp Stings     Other

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specific Allergy: \_\_\_\_\_

If the patient thinks he/she has been exposed to the above named allergen:

Observe patient for symptoms of anaphylaxis X 2 hours

Administer Epinephrine before symptoms occur, IM:  EPIPEN Adult     EPIPEN JR

Administer Epinephrine if symptoms occur, IM:  EPIPEN Adult     EPIPEN JR

Administer Benadryl per appropriate age/weight dose

Call 911, transport to ER

If the patient is experiencing respiratory distress (shortness of breath, wheezing, coughing):

Administer  PUFFS of \_\_\_\_\_ INHALER, REPEAT \_\_\_\_\_

Call 911, transport to ER

Side effects, if any, to be observed: \_\_\_\_\_

## **CAMPER IS TO CARRY & MAY SELF-ADMINISTER EPIPEN / INHALER WHILE AT CAMP:**

Yes     No

Physician's Stamp:

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- I REQUEST THAT MEDICATION BE ADMINISTERED TO MY CHILD AS DIRECTED AND DESCRIBED ABOVE BY CAMP PERSONNEL AND GIVE PERMISSION FOR THE EXCHANGE OF INFORMATION BETWEEN THE PRESCRIBER AND CAMP NURSE AS NECESSARY TO ENSURE THE SAFE ADMINISTRATION OF THIS MEDICATION. I UNDERSTAND I MUST SUPPLY THE CAMP WITH THE NECESSARY MEDICATION.
- IF APPROVED BY THE PHYSICIAN ABOVE, I REQUEST AND GIVE MY PERMISSION FOR MY CHILD TO CARRY AND SELF ADMINISTER THE MEDICATION.

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Address: \_\_\_\_\_ Town/State: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_