FOOD 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 FOOD 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

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

*Signature*_____*M.D.*

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