Date Plan was Developed:_____

Camper Photo Here

TAMARAK DAY CAMP

SEVERE ALLERGY ACTION PLAN

(Must be completed by a licensed health professional)

NAME			**Severe ALLERGY to:**
Other allergies:			
Group	**Bus #**	**Birthdate**	**Routine medications (at home/school)**
Asthmatic? (High risk for severe reaction): ☐ Yes ☐ No			Date of last reaction:
Please list the specific symptoms the camper has experienced in the past:			

Location(s) where Epi-pen/Rescue medications is/are stored:
☐ Office ☐ Backpack ☐ On Camper ☐ Counselor ☐ Other_____________

ACTION PLAN

If you suspect a severe allergic reaction to bees or food, immediately determine the symptoms and treat the reaction as follows:

Symptoms (known symptoms 'X')		**Give Medication (X)**	
☐ MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth	☐ Antihistamine	☐ Epipen
☐ SKIN	Hives, itchy rash, and/or swelling about the face or extremities	☐ Antihistamine	☐ Epipen
☐ THROAT	Sense of tightness in the throat, hoarseness and hacking cough	☐ Antihistamine	☐ Epipen
☐ GUT	Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea	☐ Antihistamine	☐ Epipen
☐ LUNG	Shortness of breath, repetitive coughing, and/or wheezing	☐ Antihistamine	☐ Epipen
☐ HEART	"Thready" pulse, "passing out", fainting, blueness, pale	☐ Antihistamine	☐ Epipen
☐ GENERAL	Panic, sudden fatigue, chills, fear of impeding doom	☐ Antihistamine	☐ Epipen
☐ OTHER	________________________________	☐ Antihistamine	☐ Epipen

- If a **food allergen** has been ingested, but no symptoms: Other: ___________ ☐ Antihistamine ☐ Epipen
- If exposure to allergen other than by ingestion (i.e., skin, inhalation) ☐ Antihistamine ☐ Epipen
- If a reaction is progressing (several of the above areas affected) ☐ Antihistamine ☐ Epipen
- **Asthma?** ☐ Yes ☐ No
- If **only** lung symptoms are present without known triggers of asthma or suspected ingestion first give: ☐ Fast acting inhaler ☐ Antihistamine ☐ Epipen
- If only inhaler is given and lung symptoms are not relieved within minutes ☐ Repeat inhaler ☐ Antihistamine ☐ Epipen

911 must be called if Epipen is administered.

Medication Doses

Antihistamine ______________________________	Dose: _____**Teaspoons** _____**Tablets by mouth**
Epipen (.03) ☐ Epipen Jr. (0.15) ☐	Side Effects:
Repeat dose of Epipen: ☐ Yes ☐ No	If YES, when

- **DO NOT HESITATE to administer Epipen and to call 911 even if the parents cannot be reached.**

	Start Date:	**End Date:**
Licensed Health Professional's Signature	Today's Date:	
	Phone:	
Licensed Health Professional's Printed Name	Fax Number:	

Licensed Health Professional (LHP) Orders / Care Plan for Severe Allergy – Part 2

- Camper should remain quiet with the nurse or a staff member until EMS arrives.
- Notify the administrator and parent/guardian.
- Provide a copy of the Severe Allergy Care Plan to EMS upon arrival.

Individual Considerations

Bus –Transportation will be alerted to camper's allergy.

- This camper carries Epipen on the bus ☐ Yes ☐ No
- Epipen can be found in: ☐ Backpack ☐ Waistpack ☐ Other______________
- Other consideration ____

Field Trip Procedures – Epipen & allergy plan will accompany camper during any off campus activities.

- The camper should remain with the unit leader during the entire field trip ☐ Yes ☐ No
- Other ____
- Staff members on trip will be trained regarding Epipen use and this Severe Allergy Care Plan.

CAMP MEALS (for campers with food allergies)

☐ Camper will sit at a specified allergy table.

This camper is allowed to eat only the following foods:

☐ Camp snacks approved by parent. : ☐ Goldfish crackers ☐ Oreo cookies ☐ Honeymaid graham crackers
☐ Alternative snacks will be provided by parent/guardian to be kept with the nurse
☐ Those in manufacturer's packaging with ingredients listed and determined allergen-free by the nurse/parent or ____
☐ **NO Restrictions**

CAMP ACTIVITIES (for campers with food allergies)

☐ Camp projects should be reviewed by the camp staff to avoid specified allergens.

EMERGENCY CONTACTS

Mother/Guardian	
Name	
Home Phone	
Cell Phone	
Work Phone	

Father/Guardian	
Name	
Home Phone	
Cell Phone	
Work Phone	

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

Parent signature gives permission for camp staff, that have been medication trained by the nurse, to administer prescribed medicine and gives permission to contact physician, if necessary.

____
Parent/Guardian Signature Date

____
Camp Nurse Signature Date

A copy of the Severe Allergy Action Plan will be kept in the nurse's office and available to all staff members who are involved with the camper.