248 Herbert Avenue, Closter, NJ 07624
(201) 784-7600 x3 • Fax: (201) 784-8261
www.palisadescountryday.com • pcdcoffice@palisadescountryday.com

Food Allergy Action Plan

ALLERGY TO: ____

Camper Name: ____________________________ D.O.B: _________________________ Place Child's Picture Here

Asthmatic: Yes* ☐ No ☐ *High risk for severe reaction

♦ Step 1: Treatment ♦

Give Checked Medications:**
(To be determined by physician authorizing treatment)

Symptoms:

▪ If a food allergen has been ingested, but *no symptoms*: ▪ Epinephrine ▪ Antihistamine ▪ Mouth Itching, tingling or swelling of the lips, tongue, or mouth ▪ Epinephrine ▪ Antihistamine ▪ Skin Hives, itchy rash, swelling about the face or extremities ▪ Epinephrine ▪ Antihistamine ▪ Gut Nausea, abdominal cramps, vomiting, or diarrhea ▪ Epinephrine ▪ Antihistamine ▪ Throat† Itching or tightness in the throat, hoarseness, and hacking cough ▪ Epinephrine ▪ Antihistamine ▪ Lung† Shortness of breath, repetitive coughing, and/or 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

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

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. Dr. ________________________________ at ________________________________

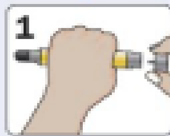
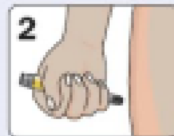
3. Emergency contacts:
Name Relationship Phone Number(s)

a. _________________________ _________________ 1.)_____________________ 2.) ____________________ b. _________________________ _________________ 1.)_____________________ 2.) ____________________ c. _________________________ _________________ 1.)_____________________ 2.) ____________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE, CALL RESCUE SQUAD OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature: ____ Date:__________

Doctor's Signature: ____ Date:__________
(Required)

EpiPen® Auto-Injector 0.3mg and its authorized generic have a yellow label and exactly the same design. Below shows EpiPen® removed from its carrier tube. EpiPen Jr® Auto-Injector 0.15mg and its authorized generic have a green label and exactly the same design. Below shows EpiPen Jr® removed from its carrier tube. 	
How to give EpiPen® or EpiPen® Jr  Form fist around EpiPen® and PULL OFF GREY SAFETY CAP.  PLACE BLACK END against outer mid-thigh (with or without clothing). PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds. REMOVE EpiPen® and DO NOT touch needle. Massage injection site for 10 seconds.	

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MEDICATION ADMINISTRATION AUTHORIZATION FORM

Dear Parents/Guardians,

Parents/Guardians of campers requesting that medication (prescription or over-the-counter) be administered during camp hours by camp personnel are required to provide the information on this form:

1. **A written parental/guardian authorization for the administration of medication.**
2. **A signed statement from the licensed prescriber.**
3. **Medication in the original prescription container, properly labeled by a registered pharmacist as prescribed by law.**

Thank you for your cooperation.

TO BE COMPLETED BY THE PHYSICIAN/LICENSED PRESCRIBER

I, ______________________, request that my patient, as listed below, receive the following medication:

Name of Student: ______________________________ Date of Birth: ______________

Diagnosis: ____

Name of Medication: ____

Prescribed Dosage: ____

Specified Time & Frequency to Be Given at Camp: ____

____ ____________________________

Physician/Licensed Prescriber Signature Date

TO BE COMPLETED BY PARENT

I, _______________________, give permission for my child to receive the above medication as directed.

____ ____________________________

Parent/Guardian Signature Date