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

*Signature*_________________________*M.D.*

****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

☐ 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.

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Patient/Parent/Guardian Signature