ANAPHYLAXIS CARE PLAN Sept. 1, 2019-Aug. 31, 2020

Name: _____ DOB:_____

ALLERGY TO: _____

Asthmatic: YES* ❑ NO ❑ *Higher risk for severe reaction

STEP 1: TREATMENT

SYMPTOMS:	GIVE CHECKED MEDICATION:
Mouth: Itching, tingling, or mild swelling of the lips	❑ Epinephrine ❑ Antihistamine
Skin: Mild hives, itchy rash	❑ Epinephrine ❑ Antihistamine
Skin: Mild hives, itchy rash unresponsive to antihistamine after 20 minutes.	❑ Epinephrine ❑ Antihistamine
Skin: Severe hives, swelling of face or extremities	❑ Epinephrine ❑ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	❑ Epinephrine ❑ Antihistamine
Throat: Tightening of the throat, hoarseness, hacking cough	❑ Epinephrine ❑ Antihistamine
Lung: Shortness of breath, repetitive coughing, wheezing	❑ Epinephrine ❑ Antihistamine
Heart: Thready pulse, low blood pressure, fainting, pale	❑ Epinephrine ❑ Antihistamine
Other: _____	❑ Epinephrine ❑ Antihistamine

DOSAGE:

*Epinephrine Intramuscularly (Circle One):

EpiPen 0.30mg EpiPen Jr. 0.15mg Twinject 0.30mg / 0.15mg

*Antihistamine: _____(medication/dose/route)

*Other: _____(medication/dose/route)

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Contact Parent _____at _____

3. Contact Emergency Contact: _____at _____

I authorize any trained or licensed day camp volunteer, nurse, or employee of Chinese Baptist Church to administer the above medication(s) if necessary for my child.

Parent/Guardian Signature:_____ Date:_____

*Note: Do Not hesitate to administer medications or call 911 even if the parents or doctor cannot be reached. The severity of a reaction can change quickly and any of the above symptoms can potentially progress to a life-threatening situation.

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT CBC

In order of any medication to be administered to a child/youth, this form must be completed and signed by the parent/guardian. Medication must be in the original properly labeled pharmacy container and will be given only as instructed on the label.

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Child's Name: _____ Birthdate: _____ Sex:_____

_____

Health Care Provider's Name Phone

Diagnosis for which medication is given:_____

Name of medicine*: _____Dose: _____

***We are unable to administer controlled substances.**

_____Tablet/Capsule ___Liquid __ Inhaler __ Nebulizer __ Other _____

If medicine is to be given **DAILY**, at what time? _____

If medicine is to be given **WHEN NEEDED**, describe indications **and** how often it can be repeated:

_____

Other information:

_____

I understand that the medication is to be furnished by me in the original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. **I authorize any trained day camp volunteer, Sunday School teacher, counselor, nurse, or employee of Chinese Baptist Church to administer the above medication if necessary for my child.** This authorization is valid for one year September 1, 2019 through August 31, 2020.

_____

Date Parent/Guardian Signature Home Phone Emergency Phone