ALLERGY CARE PLAN

DOES YOUR CHILD HAVE ANY ALLERGY? IF YES, THIS FORM MUST BE SIGNED BY A PHYSICIAN.

Child's Name ____ Date of Birth _____________________

Child is Allergic to: ____

SIGNS OF AN ALLERGIC REACTION (Check all that apply)

__Mouth/Throat: itching or swelling of the tongue, mouth throat, throat tightness, hoarseness or cough.

__Skin: hives, itchy rash, or swelling

__Gut: nausea, abdominal cramps, vomiting, diarrhea

__Lung: shortness of breath, coughing, wheezing

__Heart: pulse is hard to detect, "passing out"

ACTION FOR MINOR REACTION

If the only symptom(s) are ____, give ____________________

Then call (Parent/Guardian) ____ Phone ___________________

ACTION FOR MAJOR REACTION

If symptom(s) are ____

Give ____

Call 911

Call (Parent/Guardian) ____ Phone ___________________

Medication Requirements (Check One)

__No medication required while attending camp. Physician's initials required ______________________

__Medication required at camp (bring original prescription labeled with camper's name, birthdate and expiration).

Physician's Name ____ Date ____________________

Physician's Signature ____ Phone___________________

Physician's Signature ____ Date____________________

Camp Director's Signature ____Date ____________________