



# Allergy Emergency Care Plan

**Directions:** Form must be completed and signed by the Health Care Provider. Parents must sign bottom of form and provide all medications with medication order form. All forms are due by June 7, 2010.

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Camp Site: \_\_\_\_\_ Camp Group: \_\_\_\_\_  
 Parent/Caregiver Name: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone (work): \_\_\_\_\_  
 Health Care Provider Treating Student for Allergy: \_\_\_\_\_ Ph: \_\_\_\_\_

**To provide assistance to student experiencing an allergic reaction:**

<p>1. Type of Allergy: _____          _____</p> <p>2. Identify triggers which start an allergic reaction:          _____          _____</p> <p>3. Possible allergic signs: _____          _____          _____</p> <p>4. OTHER CONSIDERATIONS: _____          _____          _____</p>	<p style="text-align: center; color: red;"><b><u>ACTIONS TO TAKE (Do This)</u></b></p> <p><b>Stay Calm.</b>  <b>Stay with the child and call for help.</b>  <b>*Give medication (if prescribed).</b>  <b>Name of med:</b> _____  <b>How to give:</b> _____  <b>Amount:</b> _____  <b>When to give/repeat:</b> _____  <b>Location of med:</b> _____</p> <p><b>OTHER:</b>          Notify parents/guardian, and document what happened using a Y incident report form.  <i>*By law a completed and signed Medication Form must be on file at the school/site before medication can be administered at the school/site.</i></p>
--	--

**CALL 911 if student has:**

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice

- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Become pale and floppy

**Administer CPR if breathing stops. Continue until paramedics arrive.**

I authorize Y personnel to implement this Allergy Emergency Plan as described.

\_\_\_\_\_

*Health Care Provider Signature*

\_\_\_\_\_

*Date*

I give consent for Y of Central Maryland authorities to take appropriate action for the safety and welfare of my child. I give my consent for Y of Central Maryland authorities to communicate with the authorized health care provider when necessary.

\_\_\_\_\_

*Parent/Caregiver Signature*

\_\_\_\_\_

*Date*