

Date Plan was Developed: \_\_\_\_\_

**TAMARAK DAY CAMP**

Camper  
Photo  
Here

**SEVERE ALLERGY ACTION PLAN**  
(Must be completed by a licensed health professional)

**NAME**

**Severe ALLERGY to:**

**Other allergies:**

**Group**

**Bus #**

**Birthdate**

**Routine medications (at home/school)**

Asthmatic? (High risk for severe reaction):  Yes  No

Date of last reaction:

Please list the specific symptoms the camper has experienced in the past:

Location(s) where Epi-pen/Rescue medications is/are stored:

Office  Backpack  On Camper  Counselor  Other \_\_\_\_\_

**ACTION PLAN**

If you suspect a severe allergic reaction to bees or food, immediately determine the symptoms and treat the reaction as follows:

**Symptoms (known symptoms 'X')**

- MOUTH Itching, tingling, or swelling of the lips, tongue, or mouth
- SKIN Hives, itchy rash, and/or swelling about the face or extremities
- THROAT Sense of tightness in the throat, hoarseness and hacking cough
- GUT Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea
- LUNG Shortness of breath, repetitive coughing, and/or wheezing
- HEART "Thready" pulse, "passing out", fainting, blueness, pale
- GENERAL Panic, sudden fatigue, chills, fear of impending doom
- OTHER \_\_\_\_\_

**Give Medication ( X )**

- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen
- Antihistamine  EpiPen

- ◆ If a **food allergen** has been ingested, but no symptoms: Other: \_\_\_\_\_
- ◆ If exposure to allergen other than by ingestion (i.e., skin, inhalation)
- ◆ If a reaction is progressing (several of the above areas affected)
- ◆ **Asthma?**  Yes  No
- ◆ If **only** lung symptoms are present without known triggers of asthma or suspected ingestion first give:  Fast acting inhaler  Antihistamine  EpiPen
- ◆ If only inhaler is given and lung symptoms are not relieved within minutes  Repeat inhaler  Antihistamine  EpiPen

**911 must be called if EpiPen is administered.**

**Medication Doses**

|                                                                                  |                                              |
|----------------------------------------------------------------------------------|----------------------------------------------|
| Antihistamine<br>_____                                                           | Dose: _____ Teaspoons _____ Tablets by mouth |
| EpiPen (.03) <input type="checkbox"/> EpiPen Jr. (0.15) <input type="checkbox"/> | Side Effects:                                |
| Repeat dose of EpiPen: <input type="checkbox"/> Yes <input type="checkbox"/> No  | If YES, when                                 |

◆ **DO NOT HESITATE to administer EpiPen and to call 911 even if the parents cannot be reached.**

|                                             |                    |                  |
|---------------------------------------------|--------------------|------------------|
|                                             | <b>Start Date:</b> | <b>End Date:</b> |
| Licensed Health Professional's Signature    | Today's Date:      |                  |
|                                             | Phone:             |                  |
| Licensed Health Professional's Printed Name | Fax Number:        |                  |

**Licensed Health Professional (LHP) Orders / Care Plan for Severe Allergy – Part 2**

- ♦ Camper should remain quiet with the nurse or a staff member until EMS arrives.
- ♦ Notify the administrator and parent/guardian.
- ♦ Provide a copy of the Severe Allergy Care Plan to EMS upon arrival.

***Individual Considerations***

**Bus –Transportation will be alerted to camper’s allergy.**

- ♦ This camper carries Epipen on the bus       Yes       No
- ♦ Epipen can be found in:     Backpack     Waistpack     Other \_\_\_\_\_
- ♦ Other consideration \_\_\_\_\_

**Field Trip Procedures – Epipen & allergy plan will accompany camper during any off campus activities.**

- ♦ The camper should remain with the unit leader during the entire field trip     Yes     No
- ♦ Other \_\_\_\_\_
- ♦ Staff members on trip will be trained regarding Epipen use and this Severe Allergy Care Plan.

**CAMP MEALS (for campers with food allergies)**

- Camper will sit at a specified allergy table.

**This camper is allowed to eat only the following foods:**

- Camp snacks approved by parent. :     Goldfish crackers     Oreo cookies     Honeymaid graham crackers
- Alternative snacks will be provided by parent/guardian to be kept with the nurse
- Those in manufacturer’s packaging with ingredients listed and determined allergen-free by the nurse/parent or \_\_\_\_\_
- NO Restrictions**

**CAMP ACTIVITIES (for campers with food allergies)**

- Camp projects should be reviewed by the camp staff to avoid specified allergens.

**EMERGENCY CONTACTS**

|                 |            |
|-----------------|------------|
| Parent/Guardian | Name       |
|                 | Home Phone |
|                 | Cell Phone |
|                 | Work Phone |

|                 |            |
|-----------------|------------|
| Parent/Guardian | Name       |
|                 | Home Phone |
|                 | Cell Phone |
|                 | Work Phone |

**ADDITIONAL EMERGENCY CONTACTS**

|    |               |        |
|----|---------------|--------|
| 1. | Relationship: | Phone: |
| 2. | Relationship: | Phone: |

*Parent signature gives permission for camp staff, that have been medication trained by the nurse, to administer prescribed medicine and gives permission to contact physician, if necessary.*

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Camp Nurse Signature Date

**A copy of the Severe Allergy Action Plan will be kept in the nurse’s office and available to all staff members who are involved with the camper.**