SEVERE ALLERGY ACTION PLAN

MUST BE COMPLETED AND SIGNED BY A LICENSED ALLERGIST.
IF YOUR CHILD REQUIRES AN EPI-PEN--YOU MUST SUPPLY YOUR OWN EPI-PENS FOR CAMP

CAMPER NAME:____

D.O.B:________________________________

If your child does NOT need this form--please write N/A in blank:

____

Camper's Name: ____________________________ DOB: __________

2020

MUST BE COMPLETED & SIGNED BY LICENSED ALLERGIST IF YOUR CHILD REQUIRES AN EPI-PEN
YOU MUST SUPPLY YOUR OWN EPI-PENS AT CAMP

Camper Name: _______________________________________ DOB: _______________

List ANY ALLERGY (to food, medicine or other) that may prompt a life-threatening allergic response.

Allergen	Severe Reaction Caused When:	Required Response	Has severe reaction ever occurred?	Dosage & Additional Instructions
	☐ Allergen is ingested ☐ Allergen touches skin ☐ Allergen is in area (air born allergy)	☐ Give epinephrine immediately after known exposure to allergen, even if no symptoms are noted. ☐ Give epinephrine at first sign of <u>any</u> symptom. ☐ Give epinephrine with signs or symptoms of anaphylaxis.	☐ Yes, Date: ____ ☐ No	
	☐ Allergen is ingested ☐ Allergen touches skin ☐ Allergen is in area (air born allergy)	☐ Give epinephrine immediately after known exposure to allergen, even if no symptoms are noted. ☐ Give epinephrine at first sign of <u>any</u> symptom. ☐ Give epinephrine with signs or symptoms of anaphylaxis.	☐ Yes, Date: ____ ☐ No	
	☐ Allergen is ingested ☐ Allergen touches skin ☐ Allergen is in area (air born allergy)	☐ Give epinephrine immediately after known exposure to allergen, even if no symptoms are noted. ☐ Give epinephrine at first sign of <u>any</u> symptom. ☐ Give epinephrine with signs or symptoms of anaphylaxis.	☐ Yes, Date: ____ ☐ No	
	☐ Allergen is ingested ☐ Allergen touches skin ☐ Allergen is in area (air born allergy)	☐ Give epinephrine immediately after known exposure to allergen, even if no symptoms are noted. ☐ Give epinephrine at first sign of <u>any</u> symptom. ☐ Give epinephrine with signs or symptoms of anaphylaxis.	☐ Yes, Date: ____ ☐ No	

Other Non-Life Threatening Allergies & Recommended Treatment:	

Allergist's Name: ____________________ **Allergist's Signature:** ____________________

Phone Number: ____________________ **Date:** ____________________

THIS FORM MUST BE SUBMITTED BY MAY 30, 2014 TO campweekaneatit@gmail.com 1

Allergist Name:____

Allergist Signature:____

Phone:____________________________________

Date:_____________________________________

this form must be submitted WITHIN ONE MONTH OF ACCEPTANCE to: info.campweekaneatit@gmail.com