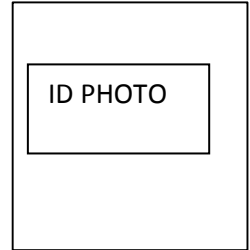


Kids Playing Camp
Anaphylaxis – Emergency Health Care Plan



ALLERGY TO: _____ **Date:** _____

Student: _____ **D.O.B.** _____ **Grade in School** _____

Asthmatic: No ____ Yes ____ *High risk for severe reaction **Weight:** _____

- Student may self-carry epinephrine
- Student may self-administer epinephrine

SIGNS OF AN ALLERGIC REACTION INCLUDE:

- | Systems: | Symptoms: |
|------------------|--|
| • MOUTH | itching and swelling of the lips, tongue, or mouth |
| • THROAT* | itching and/or a sense of tightness in the throat, hoarseness, and hacking cough |
| • SKIN | hives, itchy rash, and/or swelling about the face or extremities |
| • GUT | nausea, abdominal cramps, vomiting, and/or diarrhea |
| • LUNG* | shortness of breath, repetitive coughing, and/or wheezing |
| • HEART* | “thready” pulse, “passing-out” |

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION FOR MINOR REACTION:

If ingestion is suspected and symptoms include _____

give _____

Medication/Dose/Route

NOTIFY PARENT(S) AND OBSERVE STUDENT IN THE HEALTH OFFICE FOR 30 MINUTES FOR SIGNS OF PROGRESSION OF SYMPTOMS. IF CONDITION DOES NOT IMPROVE IN 10 MINUTES, FOLLOW STEPS FOR MAJOR REACTION BELOW.

ACTION FOR MAJOR REACTION:

1. If ingestion is suspected and symptoms include _____

give _____ **IMMEDIATELY!**

Medication/Dose/Route

and _____ **IMMEDIATELY!**

Medication/Dose/Route

2. CALL 911 RESCUE SQUAD IMMEDIATELY AFTER THE EPI-PEN IS ADMINISTERED.

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS CANNOT BE REACHED

EMERGENCY CONTACTS

Parent/Guardian #1: _____ Phone: _____

Parent/Guardian #2: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Physician Signature: _____ Date: _____

Physician Name (Please Print) : _____

Physician Phone Number: _____

I hereby authorize Kids Playing Camp to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize Kids Playing Camp staff members to disclose my child's protected health information to the student's counselors and any other appropriate camp personnel to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ Date: _____

TRAINED STAFF MEMBERS

1. _____ Group: _____

2. _____ Group: _____

3. _____ Group: _____