Allergy Action Plan

Place Child's Picture Here

If this document does not apply for my child, please sign: _____
If this document does apply, please fill out the form below.
(Must be submitted along with the Medication Authorization Form and a Doctor's Note)

ALLERGY TO:_____

Child's Name_____D.O.B._____Program:_____

Asthmatic Yes*_____ No _____ *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION
Systems: Symptoms:

- **MOUTH** itching & 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 canpotentially progress to a life threatening situation.

***** ACTION FOR MINOR REACTION *****

1. If only symptom(s) are_____

give_____
Medication and dosage

2. Then call:

Mother:_____
Home/Work/Cell

Father:_____
Home/Work/Cell

Or emergency contacts

If conditioPn does not improve within 10 minutes, follow steps for major reaction below.

***** ACTION FOR MAJOR REACTION *****

1. If ingestion is suspected and/or symptoms are_____ ,

give _____IMMEDIATELY!

2. Then call:
911- (ask for advanced life support)

Mother:_____
Home/Work/Cell

Father:_____
Home/Work/Cell

Or emergency contacts

CALL 911 IMMEDIATELY

Doctor's Name_____ Phone_____

EMERGENCY CONTACTS

1. _____ Phone_____

2. _____ Phone_____

3. _____ Phone_____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. **Pull off gray activation cap.**
2. **Hold black tip near outer thigh (always apply to thigh).**
3. **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EPIPEN® unit should then be removed and taken with you to the emergency room. Massage the injection area for 10 seconds.**

I have taught the following teachers the correct use of EPI Pen for my child named above:

1. _____

I have been trained by_____ on_____and feel comfortable with my training. Initia l_____

2. _____

I have been trained by_____on_____and feel comfortable with my training. Initial _____

3. _____

I have been trained by _____on_____and feel comfortable with my training. Initial _____

I give YMCA personnel permission to administer care to my child should they see symptoms of an allergic reaction. I understand that when the EPI Pen is used, my emergency contacts or I will be notified immediately along with ambulance personnel.

I understand that YMCA personnel will follow this action plan to the best of their ability, but are not trained medical professionals.

Parent's Signature_____ Date_____

Director's Signature_____ Date_____

Doctor's Signature(required)_____ Date_____

For children with multiple food allergies, use one form for each food