Roswell Presbyterian Youth Experience
Allergy Care Plan for Overnight Trips

Student Name:_____ **Birth Date:** _____

Allergy/ies:_____

***STEP 1: TREATMENT**

Symptoms: Give Checked Medication:

****(To be determined by physician authorizing treatment)**

1) If a food allergen has been ingested, but *no symptoms*: □Epinephrine □ Antihistamine
2) Mouth* Itching, tingling, or swelling of lips, tongue, mouth □Epinephrine □ Antihistamine
3) Skin: Hives, itchy rash, swelling of the face or extremities □Epinephrine □ Antihistamine
4) Gut: Nausea, abdominal cramps, vomiting, diarrhea □Epinephrine □ Antihistamine
5) Throat*: Tightening of throat, hoarseness, hacking cough □Epinephrine □ Antihistamine
6) Lung*: Shortness of breath, repetitive coughing, wheezing □Epinephrine □ Antihistamine
7) Heart*: Thready pulse, low bld pres., fainting, pale, blueness □Epinephrine □ Antihistamine
8) Other* _____ □Epinephrine □ Antihistamine
9) If reaction is progressing (several areas above affected) □Epinephrine □ Antihistamine

***Food Allergy is potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY MEDICATION DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Administration Instructions: _____

Antihistamine: give medication/dose/route: _____

Other: give medication/dose/route: _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace Epinephrine in anaphylaxis.

***STEP 2: EMERGENCY CALLS**

1. Call 911 or Rescue Squad: _____.

***State that an allergic reaction has been treated and additional Epinephrine may be needed.**

2. Physician's Full Name: _____ Office Phone: _____

3. Emergency contacts: Name/Relationship and Phone Number(s)

1. _____ 2._____ 3. _____

. _____ . _____ . _____

Parent/Guardian Signature_____ _____ Date_____