ROARING MOUSE CREATIVE ARTS STUDIO, LLC
MEDICATION, FOOD ALLERGY & ANAPHYLAXIS EMERGENCY ACTION PLAN

If your child will be bringing epinephrine or other medications to camp please complete and return this form.

Child's Name _____ Date of Birth _____ Age _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes _____ (Higher risk for severe reaction) No _____

Your child's food allergy response kit should be in a clear Ziploc bag labeled with their first and last name and contain at least two doses of epinephrine, other medications as noted by the child's physician, and a copy of this Food Allergy & Anaphylaxis Emergency Care Action Plan.

My child is extremely reactive to the following foods: (provide any important info related to your child's allergies)

_____

_____

Therefore:

- ❑ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
- ❑ If checked, give epinephrine if the allergen was definitely eaten, even if no symptoms are noted.

MEDICATION/DOSES: (Select all that apply)

❑ **Epinephrine**: Inject epinephrine in thigh using (Check one)

- ❑ Adrenaclick (0.15 mg)
- ❑ AuviQ (0.15 mg)
- ❑ EpiPen Jr (0.15 mg)
- ❑ Twinjet (0.15 mg)
- ❑ Adrenaclick (0.3 mg)
- ❑ AuviQ (0.3 mg)
- ❑ EpiPen (0.3 mg)
- ❑ Twinjet (0.3 mg)

❑ **Antihistamine:** (brand and dose):

_____

❑ **Other** (e.g., inhaler bronchodilator if asthmatic, brand and dose):

_____

Monitoring Plan: In the case of an emergency, we will stay with the child and alert healthcare professionals and guardians. We will get all the child's additional emergency paperwork to look for other concurrent medications or additional health problems besides anaphylaxis that can be relayed to emergency personnel upon arrival.

Emergency calls

1. **Call 911 first.** State that an allergic reaction has been treated (note time medication was administered or injected), and additional epinephrine may be needed.

2. **Call health care provider**: _____ Phone: _____

3. **Call guardian**.

Name(s): _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

Call student's emergency contacts if guardian listed cannot be reached:

Emergency contact #1:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

Emergency contact #2:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

Emergency contact #3:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

State law prevents our personnel from administering medication unless we have a signed note from a physician stating dosage and procedure. If medication is required to be administered during child care hours, please bring this form and the medication in its prescription bottle and give it to a staff member. All medications must be dispersed by a staff member. Please do not leave medication in the possession of your child or in his/her lunch box. Let us know if the medication needs to be stored in a special way (i.e. in the refrigerator, or away from sunlight.)

Please sign below to authorize staff to assist in the dispensing of medication including epipens, inhalers, and other medications as prescribed above.

Physician Signature _____ Date _____

Physician Printed Name _____ Phone _____

I authorize the program staff to administer the above medication(s) and/or treatment(s).

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

(For office use only.)

****

Date:				
Administered By:				
Time Given:				
Medication Dosage:				
Notes:				

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