ANAPHYLAXIS
Individual Treatment Plan
Complete one for EACH allergen

Estes Park Center
YMCA of the Rockies
Youth Programs

Place child's photo here

Camper Name: _____ Date of Birth: _____ Camp Week #:_____

SEVERE ALLERGY TO: _____

History:

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

STEP 1: TREATMENT

SEVERE SYMPTOMS:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (e.g. eyes, lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT: Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY – Give EpiPen®/EpiPen® Jr** into the outside of the thigh muscle, through clothing if necessary
2. Call 222 on grounds; Dial 911 off grounds. EpiPen® only lasts 20-30 minutes.
3. A second dose of EpiPen® might be needed if the life threatening reactions reoccur once the first dose has worm off & the paramedics have not yet arrived.
4. Contact Day Camp Health Care Coordinator or Youth Programs Director.

☐ **Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms**

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. Give Antihistamine
2. Radio or call Day Camp Health Care Coordinator at x1131
3. Stay with the child; keep them quiet, monitor symptoms until parent arrives.
4. If symptoms progress (see above), USE EPINEPHRINE
5. Continue monitoring

DOSAGE:

Epinephrine: Inject intramuscularly using auto-injector (check one):

☐ **0.3mg** ☐ **0.15mg**

☐ Administer 2nd dose if symptoms do not improve in _____ minutes.

Antihistamine: (brand and dose)_____

If asthmatic: (brand and dose)_____

Camper has been instructed and is capable of carrying and self-administering own medication: ☐ YES ☐ NO

Health Care Provider (print):_____ Phone:_____

Health Care Provider's Signature:_____ Date:_____

STEP 2: EMERGENCY CALLS

1. If epinephrine is given, **call 222.** State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent:_____ Phone:_____
3. Emergency Contacts – Name/Relationship: Phone number(s):
   a. _____ Phone 1:_____ Phone 2:_____
   b. _____ Phone 1:_____ Phone 2:_____

I give permission for camp personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the camp with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

_____	_____	_____	_____
Custodial Parent/Legal Guardian Signature	Printed Name	Phone	Date
_____	_____	_____	_____
Physician's Signature	Printed Name	Phone	Date

Email this completed form to: daycampepc@ymcarockies.org or Fax to Youth Programs: 970-577-1255
Phone: 970-586-3341, ext. 1280