MANCHESTER SCHOOLS/TOWN CAMP PROGRAMS
LIFE THREATENING ALLERGY TREATMENT PLAN
AND PERMISSION FOR THE ADMINISTRATION OF MEDICATIONS BY SCHOOL/CAMP PERSONNEL

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ TELEPHONE: _____

PHYSICIAN'S NAME: _____ PATIENT'S PCP: _____

ASTHMA □ YES □ NO

SPECIFIC ALLERGY: _____

IF PATIENT HAS BEEN EXPOSED TO OR INGESTED, OR THINKS HE/SHE HAS BEEN EXPOSED TO OR INGESTED THE ABOVE NAMED ALLERGEN; CHECK ALL THAT APPLY

_____ Observe patient for symptoms of anaphylaxis * * X 2 hours

_____ Administer **adrenaline** before symptoms occur EpiPen Jr .15mg Adult .3 mg

_____ Administer **adrenaline** if symptoms occur EpiPen Jr. .15mg Adult .3 mg

_____ Administer Benadryl _____tsp. or Atarax _____ tsp. Swish & Swallow

_____ Administer _____

_____Call 911, transport to ER if symptoms occur for evaluation, treatment and observation X 4 hours

_____Other steps…

1. Is this a controlled drug: □ Yes □ No
2. Medication shall be administered from _____ to _____
3. Relevant side effects, if any, to be observed: _____
4. Other suggestions: _____
5. Is the child able to self administer the above medication? □ Yes □ No

Signature _____M.D. *Today's Date* _____

**** SYMPTOMS OF ANAPHYLAXIS**
Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue, throat
Itching mouth, itchy skin
Hives or swelling
Stomach cramps, vomiting, or diarrhea
Dizziness or faintness

I HAVE RECEIVED, REVIEWED, AND UNDERSTAND THE ABOVE INFORMATION

_____
Patient / parent / guardian signature

Date / Initials _____ _____ _____

_____ _____ _____

Allergy Treatment Plan

Revised 6/21/10