

Warren Township Recreation Anaphylaxis Treatment Plan

Child's Name: _____ DOB: _____ Allergic to: _____

1. I authorize my child to self-administer epinephrine.

1. _____

YES (PARENT SIGNATURE)

- ❖ I will provide my child and the camp with **TWO auto-injector epinephrine units** And/ or oral meds and all forms.
- ❖ My child will **"Self Carry"** the epinephrine & 1 dose of oral medication at all times.
- ❖ The camp has an Adult Delegate who can administer the Auto-injector Epinephrine ONLY if needed.
- ❖ My child is capable and has been instructed by their physician in the proper method of self-administering the epinephrine and/ or antihistamines named above in accordance with NJ Law (N.J.S.A. 18A:40-12.3).

2. I do NOT authorize my child to self-administer epinephrine.

2. _____

YES (PARENT SIGNATURE)

- ❖ My child with **NOT self-carry** Auto-injector epinephrine or other medications.
- ❖ I will provide the camp with **at least TWO Auto-injector Epinephrine** and/ or oral medications and physician orders.
- ❖ The camp has a trained Adult Delegate who can administer the Auto-injector Epinephrine during camp hours.

3. My child has allergies, but is NOT anaphylactic.

3. _____

YES (PARENT SIGNATURE)

- ❖ Only Antihistamines and/or steroids will be provided with physicians orders.

4. My child does NOT require medical treatment for allergies.

4. _____

YES (PARENT SIGNATURE)

I acknowledge that if the procedures specified in the "Training Standards for the Administration of Epinephrine via Auto-Injectors" are followed, the township shall not have any liability as a result of any injury arising from the administration of a pre-filled, auto-injector mechanism containing epinephrine to the child. The parents or guardians shall indemnify and hold harmless the township and its employees or agents against any claims arising out of the administration of a pre-filled, auto-injector mechanism containing epinephrine to the camper.

Signature of Parent/ Guardian

Print Name of Parent/ Guardian

Date

Signature of Physician

Print Name of Parent/ Guardian

Date

INDIVIDUALIZED HEALTH PLAN FOR ANAPHYLAXIS/ SEVERE ALLERGIES

Child's Name: _____ DOB: _____ Grade: _____

Allergic to: _____

	S/S for Treatment	Medication	Medication	Side Effects
	If a food allergen has been ingested, but NO SYMPTOMS	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Mouth	Itching, tingling or swelling in lips, tongue, or mouth	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Abdominal	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Throat	Tightening of throat, hoarseness, hackling cough	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Lung	Shortness of breath, repetitive coughing, wheezing	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Heart	Weak or thread pulse, passing out, fainting, pale, blue	Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	
Other		Epinephrine <input type="checkbox"/>	Antihistamine <input type="checkbox"/>	

1. **Epinephrine: IM (circle one):** *EpiPen 0.3pmg *EpiPen Jr.0.15mg **Twinject 0.3mg **Twinject 0.15mg
 * (Two Auto-injectors must be provided, regardless of brand/ style) ** (Delegate my ONLY give auto-injector portion of the Twinject)

2. **Antihistamine:** _____ Dose: _____ Frequency: _____

3. **Other** _____ Dose: _____ Frequency: _____

Asthma: Yes _____ No _____ Rx: _____

The delegate cannot administer any oral medication.

Physician Stamp

Physician Signature: _____ Date: _____

Physician Name: _____ Telephone: _____

Call 911 "Allergic reaction was treated with Epinephrine- transport to hospital required"

Parent/ Guardian: _____ Home phone: _____ Cell phone: _____

Parent/ Guardian Signature: _____ Date: _____

Additional Contact Name: _____ Phone: _____

Additional Contact Name: _____ Phone: _____

Delegate: _____ Delegate: _____

Locations of Auto-injector Epinephrine: 1. _____ 2. _____

Camp Director Signature: _____ Date: _____