# MONMOUTH COUNTY PARK SYSTEM
# ALLERGY ACTION PLAN

**Place Child's Picture Here**

**ALLERGY TO**: _____

**Participant's Name:** _____ **D.O.B.** _____

**Asthmatic:** **YES** **NO** **High Risk for Severe Reaction?** **YES** **NO**

## SIGNS OF AN ALLERGIC REACTION

| SYSTEMS: | SYMPTONS: |
|---|---|
| • MOUTH | itching & swelling of the lips, tongue, or mouth. |
| • THROAT* | itching and/or a sense of tightness in the throat, hoarseness, and hacking cough. |
| • SKIN | hives, itchy rash, and/or swelling about the face or extremities. |
| • GUT | nausea, abdominal cramps, vomiting and/or diarrhea. |
| • LUNG* | shortness of breath, repetitive coughing and/or wheezing. |
| • HEART* | "thready" pulse, passing out. |

*** Above symptoms can potentially progress to a life threatening situation.**
**The severity of the symptoms can quickly change.**

**ACTION FOR MINOR REACTION**

1. **If only symptom(s) are:** _____ **give** _____
   _____
   **THEN CALL:**
2. **Parent/Guardian 1** _____ **Parent/Guardian 2** _____
   **EMERGENCY CONTACTS**
3. **Doctor** _____ **at** _____

**If condition does not improve within 10 minutes, follow steps for a Major Reaction below:**

**ACTION FOR A MAJOR REACTION**

1. **If ingestion is suspected and/or symptom(s):** _____
   **give** _____ **IMMEDIATELY**
   **THEN CALL:**
2. **Rescue Squad (ask for Advanced Life Support)**
3. **Parent/Guardian 1** _____ **Parent/Guardian 2** _____
   **EMERGENCY CONTACTS**
4. **Doctor** _____ **at** _____

**Physician's Signature:** _____

***I give my permission for trained Monmouth County Park System staff to administer the above medications.***

**Parent/Guardian Signature:** _____

# MONMOUTH COUNTY PARK SYSTEM
## MEDICATION AUTHORIZATION FORM

**Participant's Name:** _____ **Date of Birth:** _____

We highly recommend and encourage that medications be administered prior to or after the camp session, however; we recognize that there may be occasions where medicine may need to be administered with supervision during the camp day. Any medication other than rescue medications (benadryl with epi-pen, epi-pen, or asthma inhaler) will only be administered with supervision at a location where a camp nurse is present such as Dorbrook Recreation Area.

1. All prescription and non-prescription medication (over the counter) require a physician's authorization and shall be labeled and stored in the original prescription container.
2. All medication is maintained under staff supervision and the staff supervises the administration of this medication. The only exception to this is Asthma inhalers, which may be carried on the person, but must be clearly labeled with doctor's protocol.
3. Parents/Guardians must sign the medication authorization form below.

### Parental Request

I, the parent/guardian of _____ request that the rescue/prescription medication prescribed by my child's physician be administered to my child by a trained staff member (for rescue medications only such as epi-pens, benadryl with epi-pens or asthma inhalers) or the camp nurse (for other prescribed medications for campers at Dorbrook Recreation Area). The medication will be brought to camp in its original container appropriately labeled by my pharmacy.

_____ _____
Signature of parent/guardian Date

_____ _____
Address Home Phone Number

_____ _____ _____ _____
City State Zip Cellular Number

### Physician's Authorization

In order to protect the health of, _____ it is necessary for him/her to have the Following medication during camp hours.

MEDICATION: _____

DOSAGE: _____

TIME to be administered: _____

Purpose of medication: _____

List any possible side effects: _____

I authorize the camp nurse or qualified staff member to administer the above medication.

Signature of Physician _____ Date _____

Address _____