



MONMOUTH COUNTY PARK SYSTEM ALLERGY ACTION PLAN



ALLERGY TO: _____

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

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

SIGNS OF AN ALLERGIC REACTION

SYSTEMS:

SYMPTOMS:

- 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, Fort Monmouth Recreation Area, and St. John Vianney High School.

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, Fort Monmouth Recreation Area, and St. John Vianney High School). 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 _____