

CHILD'S NAME: _____ CAMP SESSION/DATES: _____

CAMP DESALES: ANAPHYLAXIS FORM

Complete form only if your child suffers from anaphylactic shock.

We want your child to receive appropriate care and support for their allergies while attending our program. Please contact Camp DeSales with any questions or concerns (517-592-2074).

ANAPHYLAXIS EXPECTATIONS

CAMP DESALES programs take place in the outdoors. Your child will be exposed to trees, insects and other environmental factors. Participants are notified of food allergies at the beginning of every meal. The closest hospital, Henry Ford Allegiance Hospital in Jackson, MI, is approximately 30 minutes away.

It is our expectation that your child is capable of self-managing their allergies: knowing which allergens to avoid, recognizing when they are experiencing an anaphylactic reaction and knowing to tell an adult immediately for help. We expect your child to know how and when to use their emergency epinephrine injector and that they will carry at least one device on their person, while at camp.

ALLERGENS

Please list what allergens cause an anaphylactic reaction in your child.

ANAPHYLAXIS SIGNS AND SYMPTOMS

Please check which signs and symptoms apply to your child's anaphylaxis response. It is assumed that the severity of these signs and symptoms can change quickly and potentially progress to a life-threatening situation.

- | | |
|--|---|
| <input type="checkbox"/> Itching of the lips, tongue, mouth and/or face | <input type="checkbox"/> Hives, an itchy rash |
| <input type="checkbox"/> Swelling of the lips, tongue, mouth and/or face | <input type="checkbox"/> Nausea, abdominal cramping, vomiting and/or diarrhea |
| <input type="checkbox"/> Itching and/or tightness in the throat | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Thread-y pulse and/or increased heart rate |
| <input type="checkbox"/> Hacking cough, repetitive cough and/or wheezing | <input type="checkbox"/> Fainting and/or loss of consciousness |

ANAPHYLAXIS HISTORY

Does your child also have asthma? Yes * No * If yes, please fill out the Asthma Form

Has your child ever self-administered the emergency epinephrine injector? Yes No* My child does not have an epinephrine injector.

*Our Health Officer is trained to assist in the administration of an emergency epinephrine injector if needed.

When did your child last experience an anaphylactic reaction? Please describe what happened and what treatment they received.

ALLERGY MEDICATION

Please list all routine and emergency allergy medications your child will bring to camp in the MEDICATION INFORMATION section of your child's health from. Send all medication in its original prescription container and label with your child's full name.

COMMUNICATION AND TREATMENT PROTOCOL

If exposure is suspected, but no signs or symptoms of anaphylaxis are present:

- Remove individual from allergen if possible.
- Monitor individual and take no further action unless signs/symptoms appear.

If exposure is suspected and signs or symptoms of anaphylaxis are present:

- Remove individual from allergen if possible.
- Assuming a patent airway, give 50mg (20mL) liquid diphenhydramine by mouth
- Administer 0.3cc epinephrine; repeat dose as needed
- Contact EMS and inform them it is an anaphylaxis situation

To follow a different protocol, have your physician write the protocol and sign below. Attach additional information as needed.

Physician Signature: _____ Date: _____

Please provide any other information you would like us to know about your child's allergic reactions. Attach additional information as needed.

Parent/Guardian Name

Relationship to Child

Phone Number

Parent/Guardian Signature _____ Date: _____