BULLIS ALLERGY ACTION PLAN

To be completed by the Physician—if applicable

Place Student's Picture Here

Camper: _____ **Date of birth:** _____

Allergy Action Plan

Reactive to the following: _____

Check one, please:

☐ Give epinephrine and recommended oral antihistamine dose immediately if exposed to allergen, even if no symptoms are noted

☐ Give epinephrine and recommended oral antihistamine dose immediately, for ANY symptoms if exposed.

Epinephrine dose ☐ **0.15 mg** ☐ **0.3 mg** **Student will carry epinephrine** ☐ **YES** ☐ **NO**

☐ Exposure to this allergen(s) does not require epinephrine. Treat per Mild Symptoms protocol below with the recommended oral antihistamine, if needed.

Oral Antihistamine (type and dosage, ex: Benadryl 25mg): _____

Any SEVERE SYMPTOMS after suspected or known ingestion.

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itch rash, swelling (e.g. eyes and lips)
GUT: Vomiting crampy pain

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1. **INJECT EPINEPHRINE IMMEDIATELY**
   - **Note time epinephrine was administered.**
2. Call 911, Alert School Nurse or ATC if on campus
   - Advise rescue squad epinephrine has been given. Request ambulance with epinephrine
3. Begin monitoring
   - A second dose of epinephrine can be given 15 minutes or more after the first symptoms persist or recur
4. Give additional medications
   - Antihistamine such as Benadryl
   - Inhaler (bronchodilator) if asthma

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

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1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent.
3. If symptoms progress, **USE EPINEPHRINE**
4. Monitor

PARENT CONTACT INFORMATION

Parent 1: _____ **Parent 2:** _____

Home #: _____ **Home #:** _____

Work #: _____ **Work #:** _____

Cell #: _____ **Cell #:** _____

Other Emergency Contact: _____ _____

Name **Contact Number**

_____ _____

Physician Signature **Date** **Affix Stamp Here**

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-adminster medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeophathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ____/____/_____

3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.	3a. FROM (mm/dd/yyyy) ____/____/_____	3b. TO (mm/dd/yyyy) ____/____/_____

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				

4. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	5b. DATE (mm/dd/yyyy)

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

6a. PARENT/GUARDIAN SIGNATURE	6b. DATE (mm/dd/yyyy)	6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE #	6e. CELL PHONE #	6f. WORK PHONE #

Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	8b. DATE