

Thompson Recreation

Emergency Treatment Form

(To be completed by child's physician)

Child's Name _____ Date of Birth _____

Address _____

Physician's Name _____ Phone _____

Physician's Address _____ Phone: _____

Asthma: Yes _____ No: _____ Allergy to: _____

Procedures for emergency treatment: (check one)

_____ Administer medication before symptoms occur if patient ingests or thinks he/she has ingested the above named food (if bee sting allergy - if stung)

_____ Observe patient for symptoms and administer medication if symptoms occur (circle symptoms below)

SYMPTOMS OF ANAPHYLAXIS (circle all those that apply to this child)

Chest tightness, cough, shortness of breath, wheezing

Hives or swelling

Tightness in throat, difficulty swallowing, hoarseness

Dizziness or fainting

Swelling of lips tongue, throat

Itchy mouth, itchy skin

Stomach cramps, vomiting, diarrhea

Medication to be administered (**number in order to be followed** and circle appropriate medicine)

_____ Administer Benadryl _____ tsp or Atarax _____ tsp swish and swallow

_____ Other: _____

_____ Transport to ER (Call 911)

_____ Contact parents

If FOOD ALLERGY, please indicate level of contact which may cause a reaction:

_____ Ingestion

_____ Touch

_____ Airborne

If ASTHMA, please list clearly the circumstances under which medication is to be given or 991 called.

Physician's Signature _____ Date _____

I give permission for Thompson Recreation/Adventure Camp personnel to administer the above medication, as indicated, to my child.

Parent's Signature _____ Date _____