

Thompson Recreation

Emergency Treatment Form (for Epi-pen)

(To be completed by child's physician)

Child's Name _____ Date of Birth _____

Child's Address _____

Physician's Name _____ Phone _____

Physician's Address _____

1. Asthma: Yes _____ No: _____ 2. 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)

MEDICATION TO BE ADMINISTERED (**number in order to be followed** and circle appropriate medicine)

_____ Administer adrenaline: Epi-Pen Jr. Epi-pen Sr.

_____ 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 CIRCUMSTANCE UNDER WHICH MEDICATION IS TO BE GIVEN OR 911 CALLED.

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

Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue, throat
Stomach cramps, vomiting, diarrhea

Hives or swelling
Dizziness or fainting
Itchy mouth, itchy skin

Physician's Signature _____ Date _____

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

Parent's Signature _____ Date _____