River Forest Park District
Allergy Action Plan

DATE FORM FILLED OUT: _____

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

ALLERGIC TO: _____ _____

_____ _____

Asthmatic Yes * ☐ No * ☐ **Higher risk for severe reaction** Yes * ☐ No * ☐

Step 1: TREATMENT

Symptoms:	**Give Checked Medication**:** (To be determined by parent or physician authorizing treatment)
☐ If an allergen has been introduced, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
☐ Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
☐ Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
☐ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
☐ Throat† Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
☐ Lung† Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
☐ Heart† Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
☐ Other† _____	☐ Epinephrine ☐ Antihistamine
☐ If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO CALL 911.

Unless otherwise arranged, ONLY paid and trained park district staff will be allowed to dispense medication.

STEP 2: EMERGENCY CALLS

1. Call 911 - State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr._____ Phone Number: _____

3. Parents: _____ Phone Number(s): _____

4. Emergency contacts:
   a. NAME: _____ Phone Number: _____

   b. NAME: _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO CALL 911.
Unless otherwise arranged, ONLY paid and trained park district staff will be allowed to dispense medication.

TRAINED STAFF MEMBERS

1. _____ _____
   Trained Staff Name Parent Signature

2. _____ _____
   Trained Staff Name Parent Signature

Parent/Guardian Signature_____ **Date**_____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.
- Hold black tip near outer thigh (always apply to thigh).
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

-Once EpiPen® or Twinject™ is used, call 911

-For children with multiple allergies, consider providing separate Action Plans for different allergies.

River Forest Park District
Medication Dispensing Information

This form must be completed for each program session or when medication changes.

BACKGROUND INFORMATION:

Participant's Name:_____ Age:_____

Address:_____

Parent's/Guardian's Name(s)_____

Daytime Phone:_____ Cell/Other Phone:_____

Program Name:_____

Doctor's Name:_____ Phone:_____

MEDICATION INFORMATION:

1. Name:_____Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

2. Name:_____Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

OTHER INFORMATION:_____

_____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

_____ _____

Signature of Parent or Guardian **Date**

River Forest Park District
Permission To Dispense Medication
Waiver and Release of All Claims

The River Forest Park District will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian. The Park District's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM:_____DATE:_____

I_____the parent/guardian of _____

Give permission to the staff of the River Forest Park District: **to administer to my child**

_____.
(Name of Medication)

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information:

PARTICIPANT'S NAME:_____

NAME OF MEDICINE AND COMPLETE DOSAGE INSTRUCTIONS:

_____

_____

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the River Forest Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. In consideration of the River Forest Park District administering medication to my minor child, I do hereby fully release or discharge the River Forest Park District, and its officer, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend the River Forest Park District, and its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child and arising out of, connected with, incidental to or in any way associated with the administering of medication.

_____ _____

Signature of Parent or Guardian **Date**