Recreation Programming
Anaphylaxis Action Plan

Program/Activity: _____

Location: _____ **Instructor:** _____

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Home Phone: _____ Work Phone: _____

Physician: _____ Work Phone: _____

Participant's Anaphylaxis Triggers:

☐ Peanuts ☐ Nuts ☐ Milk ☐ Dairy ☐ Eggs ☐ Shellfish ☐ Fish

☐ Food additives (list): _____
☐ Insect stings (list): _____
☐ Medications (list): _____
☐ Others (list): _____

Participant's Anaphylaxis Symptoms:

☐ Swelling (eyes, lips, face, and tongue)
☐ Vomiting
☐ Difficulty breathing or swallowing
☐ Coughing or choking
☐ Cold, clammy, and sweaty skin
☐ Stomach cramps, diarrhea
☐ Flushed face or body
☐ Dizziness or confusion
☐ Fainting or loss of consciousness
☐ Changes in voice/speaking pattern
☐ Others (list): _____

Prescribed Treatment:

☐ Anti-histamine (please complete Administration and Health CareProvision Form)
☐ EpiPen® (must be kept with the child at all times)

Recreation Programming Staff are not trained in the use of Ana Kits. EpiPens® must be provided.

CALL 911 AND TELL THE DISPATCHER THAT A CHILD IS HAVING A LIFE-THREATENING ANAPHYLACTIC REACTION.
CALL THE PARENT OR GUARDIAN

Parent/Guardian Signature: _____ **Date:** _____