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): ______________________________
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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:** ______________