Form A

AUTHORIZATION FOR EMERGENCY CARE

OF CHILDREN WITH SEVERE ALLERGIES

Dear Doctor: _____Date:_____

Your patient, _____ is enrolled/enrolling in the Town of Kensington's Summer Camp program and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at the Town so we may assist with the allergy care and needs of our enrollee and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at the Town.

PART I (to be completed by physician)

Child's Name: _____Child's Birth Date: _____

Allergens:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (eg. anaphylactic shock) in the child.

____ Bee Sting

____ Other Insect Bite(s): (identify):_____

____Animal Fur: (identify):_____

____Food Allergy: (identify all foods that must be avoided):_____

_____

Other: (identify):_____

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Symptoms

Please provide a complete list of all symptoms that indicate that the child has come into contact with an allergen and that he or she requires emergency treatment.

____Shortness of Breath or Difficulty in Breathing

____Swelling of the Face or Lips

____Hives

____Vomiting

____Diarrhea

____Other: (Explain): _____

____Do not administer medication in the absence of known exposure to allergen.

(Explain): _____

Procedures

Please indicate all steps necessary and the numeric order in which they should be taken; also indicate if steps should be administered immediately upon exposure to allergen.

____Give Benadryl Elixir, ml orally.

____Administer EpiPen, Jr. or _____

____Call the emergency medical personnel (e.g. "911").

____Call parent(s)/guardian(s), and child's physician.

____Child may self administer his or her own medication.

____Other

(Explain): _____

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Recreational Activities

1. The child may participate in recreational activities. [ ] Yes [ ] No
2. Activity restrictions: [ ] None [ ] Some Restrictions

   (Explain):_____

Child's Physician

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

Signature: _____Date:_____

PART II (to be completed by Parent(s)/Guardian(s))

Parent(s)/ Guardian(s)

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

Name: _____

Address: _____

Form A

Telephone No.: _____

Emergency Contact No.: _____

By signing this form, I/We authorize the Town to follow the above instructions in the Authorization form. I/We agree to update this form every six (6) months or sooner if my/our child's needs change.

Signature: _____

Parent(s)/Guardian(s)

Date: _____

Signature: _____

Parent(s)/Guardian(s)

Date: _____