# COMMUNITY RECREATION ALLERGY FORM

Children's Specialized Hospital

CHILD'S NAME:_____DATE OF BIRTH: _____

ALLERGY TO: _____

| SYMPTOMS | GIVE CHECKED MEDICATION |
|---|---|
| If an exposure to the allergens has occurred, but there are no symptoms | ☐ Antihistamine ☐ Epinephrine |
| **Mouth:** itching, tingling, swelling of lips, tongue, mouth | ☐ Antihistamine ☐ Epinephrine |
| **Skin:** hives, itchy rash, swelling of face or extremities | ☐ Antihistamine ☐ Epinephrine |
| **Gut:** nausea, abdominal cramping, vomiting, diarrhea | ☐ Antihistamine ☐ Epinephrine |
| **Throat:** tightening, hoarseness, hacking cough | ☐ Antihistamine ☐ Epinephrine |
| **Lung:** shortness of breath, repetitive cough, wheezing | ☐ Antihistamine ☐ Epinephrine |
| **Heart:** weak or thread pulse, low blood pressure, fainting, pale, blueness | ☐ Antihistamine ☐ Epinephrine |
| **Other symptoms:** | ☐ Antihistamine ☐ Epinephrine |
| If reaction is progressing, several of the above areas affected: | ☐ Antihistamine ☐ Epinephrine |

DOSAGE

Epinephrine (inject intramuscularly)

☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3 mg ☐ Twinject 0.15mg

Antihistamine: give _____

Medication/dose/route

Other: give _____

Medication/dose/route

If a reaction occurs medication will be administered by program staff, 911 will be called, then emergency contacts. A child's physician may also be contacted.

_____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

SIGNATURE OF PHYSICIAN DATE

_____

Name of Physician and Practice

Please note that this form must be updated by parents/caregivers annually or when information changes. Updated 10/21/16