



73 East Valley Brook Road  
Long Valley, NJ 07853  
Phone: (908) 876-3429

Office Use Only

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B:

## ALLERGY ACTION PLAN

If your child has any allergies, please complete and return this form to Meadowbrook with your physician's orders for the administration of appropriate medication or Epi Pen.

If your child rides a bus to camp, please provide a second Epi Pen to be kept on the bus.

Camper Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

**ALLERGIES** - List all known

Describe reaction and management of the reaction

**Food Allergies (list)**

\_\_\_\_\_

\_\_\_\_\_

**Medication Allergies (list)**

\_\_\_\_\_

\_\_\_\_\_

**Other Allergies (list)** - include asthma, insect stings, hay fever, animal dander, etc.

\_\_\_\_\_

\_\_\_\_\_

### BELOW IS TO BE FILLED OUT AND SIGNED BY YOUR CHILD'S PHYSICIAN

**ACTION FOR MINOR REACTION** - to be administered by authorized camp personnel.

If only symptoms are \_\_\_\_\_ give \_\_\_\_\_  
medication/dose

Then call:

1. Mother \_\_\_\_\_, Father \_\_\_\_\_, or emergency contacts.  
Name, Phone Name, Phone

2. Dr. \_\_\_\_\_  
Name, Phone

**If condition does not improve within 10 minutes, follow the steps for Major Reaction below.**

**ACTION FOR MAJOR REACTION**

If ingestion is suspected and/or symptoms are \_\_\_\_\_

give \_\_\_\_\_ **IMMEDIATELY!**

**Then Call:**

**1. Rescue Squad (ask for advanced life support). Do Not hesitate to call Rescue Squad!**

2. Mother \_\_\_\_\_, Father \_\_\_\_\_, or emergency contacts.  
Name, Phone Name, Phone

3. Dr. \_\_\_\_\_  
Name, Phone

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_