FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Metro Chicago
SPECIAL MEDICAL INFORMATION – SEVERE ALLERGY & ANAPHYLAXIS EMERGENCY PLAN

MEMBER INFORMATION – PLEASE PRINT

Child's name (first & last): _____ Date of Birth: _____

Allergy to: _____ Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLEASE NOTE: It is generally recommended not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction, but instead to USE EPINEPHRINE. If epinephrine is administered, the YMCA will call 911 immediately.

EXTREMELY REACTIVE

☐ If this box is checked, even if mild symptoms occur after a sting or eating these foods, the YMCA will give epinephrine.

For Mild to Moderate Reaction, please choose below:

The medication given is to be determined by physician authorizing treatment.

NO SYMPTOMS
If a food allergen has been ingested, but no symptoms
Give: ☐ Epinephrine ☐ Antihistamine

MOUTH
Itching, tingling, or swelling of lips, tongue, mouth
Give: ☐ Epinephrine ☐ Antihistamine

SKIN
Hives, itchy rash, swelling of face or extremities
Give: ☐ Epinephrine ☐ Antihistamine

GUT
Nausea, abdominal cramps, vomiting, diarrhea
Give: ☐ Epinephrine ☐ Antihistamine

THROAT
Tightening of throat, hoarseness, hacking cough
Give: ☐ Epinephrine ☐ Antihistamine

LUNG
Shortness of breath, repetitive coughing, wheezing
Give: ☐ Epinephrine ☐ Antihistamine

NOSE
Itchy or runny nose, sneezing
Give: ☐ Epinephrine ☐ Antihistamine

HEART
Thready pulse, low blood pressure, faint, pale, blueness
Give: ☐ Epinephrine ☐ Antihistamine

OTHER
Please Specify: _____
Give: ☐ Epinephrine ☐ Antihistamine

COMBINATION
Symptoms from the different body areas above
Give: ☐ Epinephrine ☐ Antihistamine

If reaction is progressing and symptoms are becoming more severe
Give: ☐ Epinephrine ☐ Antihistamine

This member recognizes the onset of an allergic reaction and can notify a YMCA member if symptoms occur. ☐ YES ☐ NO

This member does not recognize and report the onset of an allergic reaction. ☐ YES ☐ NO

This member is trained to administer his/her own epinephrine injection. ☐ YES ☐ NO

MEDICATION DOSING INFORMATION

*The Permission to Dispense Medication form must also be completed

☐ Epi Pen® ☐ EpiPen® Jr. ☐ Auvi-Q™ 0.3mg ☐ Auvi-Q™ 0.15mg ☐ Adrenaclick 0.3mg ☐ Adrenaclick 0.15mg

☐ Other (specify brand & dosage) _____

ANTIHISTAMINE:

Name: _____

Dosage/Method for administration: _____

OTHER

Name: _____

Dosage/Method for administration: _____

ASTHMA MEDICATION

Name: _____

Dosage/Method for administration: _____

EMERGENCY CALLS – IF EPENEPHRINE IS GIVEN

1: 911

2: Parent/Guardian 1: _____ Phone Number: _____

3: Parent/Guardian 2: _____ Phone Number: _____

4: Physician's Name: _____ Phone Number: _____

5: Emergency Contact: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Additional Information: