LINCOLNWOOD
SUMMER DAY CAMP

Camper ID Card

Place Photo of Child Here

Date: _____

Camp Name: _____

Child's Name: _____

Date of Birth: ____/____/____ Gender

Height: _____**Feet** _____**Inches** **Weight:** _____**lbs.**

Eye Color: _____ **Hair Color:** _____

Distinguishing Marks/Features:

_____

_____

_____

_____

Does the camper have allergies? _____ **Asthmatic? Yes or No (circle or select)**

**If your child has allergies please complete section below*

Complete this section ONLY if your child has allergies

Treatment for the following symptoms:	**Give Checked Medication****	
	**(To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but *no symptoms:*	☐ Epinephrine	☐ Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat †: Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung †: Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart †: Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other † _____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

† Potentially life-threatening.

Continued on reverse ➡

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Allergy information continued

Dosage amounts:

Epinephrine: inject intramuscularly (circle one)

EpiPen ® ☐ EpiPen Jr. ® ☐

Lot # _____

Twinject ™ 0.3mg ☐ Twinject™ 0.15mg ☐

Expiration Date: _____

Antihistamine: give _____

medication/dose/route

Other: give _____

medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Emergency Calls:

1. Call 911 and state that an allergic reaction bas been treaded, and additional epinephrine may be needed.

2. Dr._____ at _____

3. Emergency Contacts: Name/Relationship	Phone Number(s)	
A._____	1._____	2._____
B._____	1._____	2._____
C._____	1._____	2._____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

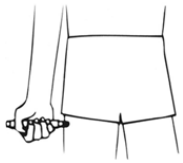
Parent/Guardian Signature_____ Date_____

Doctor's Signature *(Required)*_____ Date _____

EpiPen® and EpiPen® Jr. Directions

1. **Pull off gray activation cap.**

2. Hold black tip near outer thigh *(always apply to thigh).*



3. Swing an jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

1. Pull off green end cap, then red end cap.

2. Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

The Food A-ergy & Anaphylaxis Network