



2020 ALLERGY INFORMATION

Please mark which camp your child is in 2-3 Year Old 4-11 Year Old

Child's name _____ Date of birth _____

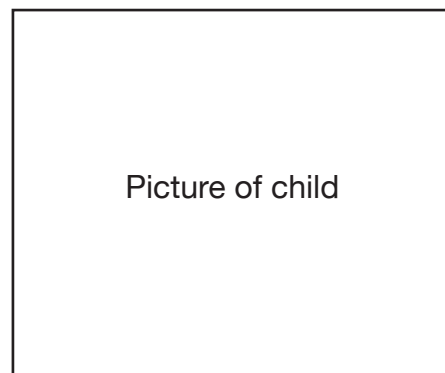
To be completed by physician or parent:

Physician's name _____ Phone # _____

Allergic To	Reaction <i>signs & symptoms</i>	EpiPen Required	Benadryl Required	Comments <i>(other medications, special precautions, etc.)</i>
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Emergency action plan:

1. Give epi-pen if needed
2. Call 911
3. Contact SJCC Lifeguards
4. Contact parents
5. Repeat epi-pen in 15-20 minutes if not improving or worsening
6. Go to hospital



Emergency contacts

1. Name _____ Phone # _____

2. Name _____ Phone # _____

3. Name _____ Phone # _____

Physician's/parent's signature _____ Date _____