Grayslake Community Park District
240 Commerce Drive
Grayslake, IL 60030
(847) 223-7529
www.glpd.com

Allergy Action Plan
Summer 2019

Participant Name	Gender	Birthdate

Address:		
City:	State:	Zip Code:

Parent/Guardian Information

Mother/Guardian 1 Information	Name:
Primary Phone:	Secondary Phone:

Father/Guardian 2 Information	Name:
Primary Phone:	Secondary Phone:

Participant Allergic To: _____

Asthmatic: □ Yes* □ No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms: **Give Checked Medication**

- If a food allergen has been ingested, but no symptoms — □ EpiPen □ Antihistamine
- Mouth - Itching, tingling or swelling of lips, tongue mouth — □ EpiPen □ Antihistamine
- Skin - Hives, itchy rash, swelling of the face or extremities — □ EpiPen □ Antihistamine
- Gut - Nausea, abdominal cramps, vomiting, diarrhea — □ EpiPen □ Antihistamine
- *Throat Tightening of throat, hoarseness, hacking cough — □ EpiPen □ Antihistamine
- *Lung - Shortness of breath, repetitive coughing, wheezing — □ EpiPen □ Antihistamine
- *Heart - Thready pulse, low blood pressure, fainting, pale, blueness — □ EpiPen □ Antihistamine
- * Other: _____ — □ EpiPen □ Antihistamine
- If reaction is progressing (several of the above areas affected), give — □ EpiPen □ Antihistamine

The severity of symptoms can quickly change ** Potentially life-threatening*

Dosage

Epinephrine: Inject intramuscularly (check one) □ EpiPen □ EpiPen Jr.

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 - State that an allergic reaction has been treated and additional epinephrine may be needed
2. Call Parent/Guardians
3. Call Emergency Contacts (Emergency Contacts must be persons other than parent/guardians listed)

Emergency Contacts

Name:	Relationship to Child:
Primary Phone:	Secondary Phone:

Name:	Relationship to Child:
Primary Phone:	Secondary Phone:

Name:	Relationship to Child:
Primary Phone:	Secondary Phone:

I give permission for my child to receive necessary health care and emergency medical treatment.

☐ Yes	☐ No	Parent/Guardian Signature:	Date:

In case of an emergency, my child may be taken to the nearest hospital by paramedics.

☐ Yes	☐ No	Parent/Guardian Signature:	Date:

I, _____, the parent/guardian of _____ give permission to the staff of the Grayslake Park District to administer the above medication to my child.

I understand it is my responsibility to give the medication directly to the program staff in the original dosage containers clearly labeled with the following information: Pharmacy's name, Doctor's name, Patient's name, Type of medications, Strength, and Dosage instructions.

In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Grayslake Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

In consideration of the Grayslake Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Grayslake Park District and its officers, agents, servants and employees from any and all claims I may have as a result of the Grayslake Park District Staff assisting in the administering of medication to my minor child.

Parent/Guardian Signature _____ **Date** _____