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

Allergy Action Plan
2021-2022 School Year

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** __________________________