



## Allergy Action Plan Summer 2026

Participant Name	Gender	Birthdate

Address:		
City:	State:	Zip Code:

### Parent/Guardian Information

<b>Mother/Guardian 1 Information</b>	Name:
Primary Phone:	Secondary Phone:

<b>Father/Guardian 2 Information</b>	Name:
Primary Phone:	Secondary Phone:

**Participant Allergic To:** \_\_\_\_\_

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

### STEP 1: TREATMENT

**Symptoms:**

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

**Give Checked Medication**

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> 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.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parent/Guardian Signature:	Date:
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**In case of an emergency, my child may be taken to the nearest hospital by paramedics.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parent/Guardian Signature:	Date:
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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 \_\_\_\_\_