

Allergy Action Plan

CAMP EMETH

11645 Ladue Road
St. Louis, MO 63141



Identification of and Authorization for Treatment of Child Care Participants
With Chronic Health Condition or Life Threatening Food Allergies
(Parent/Guardian should complete, we encourage Physician review)

Child's Name: _____

Health Condition(s): _____
(i.e.: Food Allergies/Asthma)

Parent(s)/Guardian(s) Names and Telephone Numbers:

_____ (work) _____ (home) _____

_____ (work) _____ (home) _____

(Cell phone) _____ (page #) _____

Please let us know which is best to reach you during camp hours

Physician(s) Name and Telephone Numbers:

- 1) Describe the child's symptoms including when they generally occur, warning signs and severity.

- 2) How are mild episodes or reactions treated?

- 3) How are serious episodes or reactions treated?

- 4) Does the child need medication or treatment? _____
 If so, is Camp Emeth to administer any medication or treatment to the child? _____
 Give details on the administration of medication or treatment required to be performed by Camp Emeth:

