BUCKLEY day camp
2 I.U. Willets Road – Roslyn, New York 11576
(Phone) 516-365-7760 – (Fax) 516-869-0964 – www.buckleycamp.com

Allergy Action Plan

For Allergies, Even Mild

Medication Auth.

If your child has severe or even mild food/environmental allergies, we ask that you fill out his form and have your doctor fill it out on the Physical Exam Report (and med auth if medication is required)

Camper's Name: ______________________________ D.O.B.____________Grade (next Sept.)______

Allergic to:	Cause of Reaction	Symptoms of Typical Reaction (please circle)	Parents Procedure for Typical Reaction	Medication Given for Typical Reaction (to be determined by md/rn authorizing treatment)
	☐ Ingestion ☐ Airborne ☐ Touch	Itching, tingling, swelling of lips/tongue, hives, rash, swelling of extremities, nausea, cramps, vomiting, diarrhea, tightening of throat, hoarse, hacking cough, shortness of breath, wheezing, weak or thread pulse, low blood pressure, fainting, pale, blueness, other:		☐ Antihistamine ☐ Epinephrine (epi-pen) ☐ Other:
	☐ Ingestion ☐ Airborne ☐ Touch	Itching, tingling, swelling of lips/tongue, hives, rash, swelling of extremities, nausea, cramps, vomiting, diarrhea, tightening of throat, hoarse, hacking cough, shortness of breath, wheezing, weak or thread pulse, low blood pressure, fainting, pale, blueness, other:		☐ Antihistamine ☐ Epinephrine (epi-pen) ☐ Other:
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General "Need to Know" Info. Regarding Your Child

Please provide any personal information you feel would help us in regard to your child's adjustment to camp (such as emotional, environmental, social…). Use additional paper if necessary.

____
____
____
____
____
____

✱ Parent's Signature: _________________________ Parent's Name: __________________ Date: ______

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Medication Authorization

For the Administration of Medication in Camp

Allergy/"Need to Know"

If your child requires medication at camp, please contact the summer office/camp nurse by June 1st. Medication with appropriate physician & parent authorization must be rec'd no later then June 12th.

*To be Completed by **PARENT/GUARDIAN:***

I request that my child _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy with the prescription, dosage, Doctor's name, and patients name listed. I understand that the camp nurse or other designated person will administer the medication.

Parent/Guardian Signature: _____ **Date**: _____

Print Name of Parent/Guardian: _____

Telephone Number: Home #: _____ Work #: _____

*To be Completed by **PHYSICIAN:***

I request that my patient, as listed above receive the following medication:

Diagnosis: _____

Medication: _____

Dosage: 1. Amount to be given: _____
2. Time to be given: _____
3. Frequency: As Needed Daily Other: _____
4. Duration of treatment: (1 week, 1 month, entire camp season) _____
4. Method to be taken: _____

Possible side effects: _____

_____

Name of Physician and title: _____

Physician's signature: _____ **Date:** _____

Address: _____

Telephone #: _____

***Turn OVER** for Allergy Action and General "Need to Know" Information*