ANAPHYLAXIS CARE PLAN

September 1, 2023-Aug. 31, 2024

Name: _____ DOB:_____

ALLERGY TO: _____

Asthmatic: YES* ❑ NO ❑ *Higher risk for severe reaction

STEP 1: TREATMENT

SYMPTOMS:	GIVE CHECKED MEDICATION:
Mouth: Itching, tingling, or mild swelling of the lips	❑ Epinephrine ❑ Antihistamine
Skin: Mild hives, itchy rash	❑ Epinephrine ❑ Antihistamine
Skin: Mild hives, itchy rash unresponsive to Antihistamine after 20 minutes.	❑ Epinephrine ❑ Antihistamine
Skin: Severe hives, swelling of face or extremities	❑ Epinephrine ❑ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	❑ Epinephrine ❑ Antihistamine
Throat: Tightening of the throat, hoarseness, hacking cough	❑ Epinephrine ❑ Antihistamine
Lung: Shortness of breath, repetitive coughing, wheezing	❑ Epinephrine ❑ Antihistamine
Heart: Thready pulse, low blood pressure, fainting, pale	❑ Epinephrine ❑ Antihistamine
Other: _____	❑ Epinephrine ❑ Antihistamine

DOSAGE:

*Epinephrine Intramuscularly (Circle One):

EpiPen 0.30mg EpiPen Jr. 0.15mg Twinject 0.30mg / 0.15mg

*Antihistamine: _____(medication/dose/route)

*Other: _____(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. Contact Parent _____at _____

3. Contact Emergency Contact: _____at _____

I authorize any trained or licensed day camp volunteer, nurse, or employee of Beacon Hill Church to administer the above medication(s) if necessary for my child.

Parent/Guardian Signature:_____ Date:_____

*Note: Do Not hesitate to administer medications or call 911 even if the parents or doctor cannot be reached. The severity of a reaction can change quickly and any of the above symptoms can potentially progress to a life-threatening situation.

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN AT BHC

In order of any medication to be administered to a child/youth, this form must be completed and signed by the parent/guardian. Medication must be in the original properly labeled pharmacy container and will be given only as instructed on the label.

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Child's Name: _____ Birthdate: _____ Sex:_____

_____

Health Care Provider's Name Phone

Diagnosis for which medication is given:_____

Name of medicine*: _____Dose: _____

***We are unable to administer controlled substances.**

_____Tablet/Capsule ___Liquid __ Inhaler __ Nebulizer __ Other _____

If medicine is to be given **DAILY**, at what time? _____

If medicine is to be given **WHEN NEEDED**, describe indications **and** how often it can be repeated:

_____

Other information:

_____

I understand that the medication is to be furnished by me in the original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. **I authorize any trained day camp volunteer, Sunday School teacher, counselor, nurse, or employee of Beacon Hill Church to administer the above medication if necessary for my child.** This authorization is valid from September 1, 2023 through August 31, 2024.

_____ _____

Parent/Guardian Signature Date

_____ _____ _____

Parent/Guardian Printed Name Home Phone Cell Phone

_____ _____ _____

Emergency Contact Relationship Emergency Phone

過敏性反應護理計劃

September 1, 2023-Aug. 31, 2024

姓名: _____ 出生日期: _____

過敏體: _____

哮喘: 是*❑ ・ 否❑ *具高風險的嚴重反應

第一步驟: 治療

症狀:	給予所勾選的藥物：	
口腔：瘙癢、刺痛、或雙唇輕度腫脹	❑腎上腺素	❑抗組織胺劑
皮膚：輕度皮疹、發癢	❑腎上腺素	❑抗組織胺劑
皮膚：輕度皮疹、抗組織胺劑服後二十分鐘無效的發癢	❑腎上腺素	❑抗組織胺劑
皮膚：嚴重皮疹、臉部或四肢腫脹	❑腎上腺素	❑抗組織胺劑
腸胃：噁心、腹部絞痛、嘔吐、腹瀉	❑腎上腺素	❑抗組織胺劑
喉嚨：喉嚨收緊、聲音嘶啞、不斷咳嗽	❑腎上腺素	❑抗組織胺劑
肺部：呼吸急促、反復咳嗽、喘氣	❑腎上腺素	❑抗組織胺劑
心臟：脈搏虛弱、血壓低、暈倒、臉色蒼白	❑腎上腺素	❑抗組織胺劑
其他： _____	❑腎上腺素	❑抗組織胺劑

劑量：

*腎上腺素肌肉注射(圈選其一)：

EpiPen 0.30mg EpiPen Jr. 0.15mg Twinject 0.30mg / 0.15mg

*抗組織胺劑：_____(藥物/劑量/療程)

*其他: _____(藥物/劑量/療程)

第二步驟: 緊急救援

1. 撥打911。陳述患者已接受了過敏反應治療，並可能需要額外的腎上腺素。

2. 聯絡家長: _____電話號碼: _____

3. 聯絡緊急聯絡人: _____電話號碼: _____

本人授權任何受過訓練或持牌的營會義工、護士或華人浸信會僱員，在必要時給本人之子女服用上述藥物。

家長/監護人簽名:_____ **日期:**_____

*注意：即使未能聯絡到家長或醫生，也要毫不遲疑地施以藥物治療或撥打911。嚴重的過敏反應可以快速變化，並且上述的任何症狀都可能發展致危及生命的情況。

營會用藥授權書

為了讓參加營會者能接受任何藥物，本表格必須由家長/監護人填寫及簽署, 藥物必須在貼有正確標籤的原裝藥房容器內，並按照標籤上的指示施藥。

以下部份是由家長/監護人填寫: (請用正楷)

孩子姓名: _____ 出生日期: _____ 性別:_____

_____

醫生姓名： 電話：

醫生的診斷結果:_____

藥物名稱*: _____藥量: _____

*我們不能給孩子服用禁制藥物。

_____藥片/藥囊 _____藥水 _____ 吸入劑 _____ 噴霧劑 _____ 其他 _____

如果藥物是**每日**服用的，該在什麼時間服用？ _____

如果藥物是**按需要**服用的, 請描述其症狀**以及**服用的頻率:

_____

其他資訊: _____

本人明白以上藥物是由本人提供，並放在原裝容器內，由藥房或處方醫生列明藥物的名稱、份量、次數、和醫生的姓名。**本人授權任何受過訓練的營會義工、持牌營會義工、護士或華人浸信會僱員，在必要時給本人之子女服用上述藥物。**此授權僅在 9/1/2023 至 8/31/2024 為期一年期間有效。(以上中文只供參考，一切內容以英文版本為準)

_____ _____

家長監護人簽名 日期

_____ _____ _____

家長/監護人正楷姓名 住家電話 手機

_____ _____ _____

緊急聯絡人 關係 緊急電話