



Science Discovery
UNIVERSITY OF COLORADO BOULDER

Allergy Care Plan

Please Note: This form should ONLY be completed if your child has a SEVERE allergy that requires monitoring and/or potential treatment by CU Science Discovery Staff. This form WILL NOT be accepted without a physician's signature.

THIS FORM IS DUE 20 BUSINESS DAYS PRIOR TO THE START OF YOUR CHILD'S CAMP

Student's Name: _____ Birthdate: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Child's Camp Name(s) and Start Date(s): _____

Allergies (please specify type of allergy and severity):

Emergency Treatment

For Mild Allergic Symptoms

- Several hives
- Swelling at site of sting
- Suspected ingestion or sting, but no symptoms
- Itchy skin
- Mild nausea/discomfort
- Nasal symptoms
- Itchy, red, watery eyes

Treatment

1. Give _____ of _____ by mouth.
dosage (amount) antihistamine
2. Contact parent/guardian or emergency contact and program director.
3. Stay with the student and monitor symptoms until parent/guardian arrives.
4. Watch student for more serious symptoms (listed below).

For Severe Allergic Symptoms (Potentially Life-Threatening)

- Hives spreading over body
- Wheezing, Difficulty swallowing or breathing
- Swelling of face/neck, Tingling or swelling of tongue
- Vomiting
- Signs of shock (extreme paleness/grey color, clammy skin)
- Loss of consciousness

Treatment

1. Inject intramuscularly immediately—place against upper outer thigh. (Check one)
 - EpiPen® 0.3mg EpiPen Jr® 0.15mg Auvi-Q Andrenaclick
 - Administer 2nd dose if symptoms do not improve in 15-20 minutes
2. Call 911 immediately and state that allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
3. Contact parent/guardian or emergency contact and program director.
4. Student should remain lying down.

Please Note: Medication must arrive in its original container labeled with child’s name and dosage. Parents are responsible for delivering the medication to CU Science Discovery. Your child will not be permitted to store medication in his or her backpack. Medication will be stored with child’s instructor or with the director.

Health Care Provider Information

(Physician’s signature indicates that a healthcare provider has approved this child to receive the indicated medication)

Physician’s Name (Please Print)

License Number

Physician’s Signature and Title
(A stamp is acceptable if title is present)

Phone Number

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. The undersigned parent or guardian hereby agrees to release, defend, and indemnify the Regents of the University of Colorado, a body corporate, CU Science Discovery, and its officers, employees, and agents, from any legal claims arising out of the administration of (or failure to administer) the medications specified above. The undersigned parent or guardian understands that the University and CU Science Discovery are not responsible for the administration of any medication and will not administer medications other than those specified in the student’s Allergy Care Plan.

I give permission for CU Science Discovery personnel to share this information, follow this plan, administer medication, care for my student and, if necessary, contact the student’s health care provider. I assume full responsibility for providing CU Science Discovery with prescribed medication and/or delivery/monitoring devices. I approve this Allergy Care Plan for my student.

Parent/Guardian Signature

Date