MEDICAL ACTION PLAN

Name _____ **DOB** _____

Medical Condition _____

_____

Symptoms:	**Give Checked Medicine** **(determined by physician authorizing treatment):**
If a food allergen has been ingested, but no symptoms	☐ Epinephrine ☐ Antihistamine
MOUTH: Itching, tingling, or swelling of the lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
SKIN: Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
GUT: Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
THROAT∗: Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
LUNGS∗: Shortness of breath, repetitive coughing, wheezing, shallow breathing, chest tightness, chest retractions	☐ Epinephrine ☐ Antihistamine
HEART∗: Weak or thready pulse, low blood pressure, fainting, blueness	☐ Epinephrine ☐ Antihistamine
FEVER: Lethargy, loss of consciousness, shaking, moving limbs on both sides of the body	☐ _____ ☐ _____
SEIZURE: Impairment of consciousness (staring blankly), repetitive blinking or other small movements, moaning	☐ _____ ☐ _____
DIABETIC: Irritability, change in personality, sweating, shaky, loss of consciousness, confusion, rapid or deep breathing, seizure, listlessness, dizziness, paleness, rapid pulse	☐ _____ ☐ _____
∗Potentially life-threatening—severity of symptoms can quickly change.	

Treatment: Rescue Medication

Epinephrine (mark one) ___EpiPen® ___EpiPen®Jr. ___Twinject®0.3mg ___Twinject®0.15mg

Inject intramuscularly (see attached for instructions)

Antihistamine _____Medicine _____Dosage _____Route

Other _____Medicine _____Dosage _____Route

Emergency Calls:

Call 911 to activate EMS under ANY of the following circumstances:

- Epinephrine has been administered. State that an allergic reaction has been treated and additional epinephrine may be needed.
- Decreased or loss of consciousness
- Lips or fingernails are blue or gray
- Child is too short of breath to walk, talk, or eat normally
- Chest and neck pulling in with breathing
- Child is hunching over
- Child is struggling to breathe

Bonhomme Church

Love God, Love People, and Make Disciples of Jesus Christ

After 911, contact the Parent or Emergency Contact Person.

Parent _____ Phone Number _____

Parent _____ Phone Number _____

Physician_____ Phone Number _____

Other Emergency Contacts (Name and Relationship)

_____ Phone Number _____

_____ Phone Number _____

Parent Consent for Medical Care at all Bonhomme Church activities

I, the parent or guardian of the above named child, request that this Medical Action Plan be used to guide medical care for my child. I agree to:

- Provide necessary supplies and equipment.
- Notify the office of any changes in the child's health status.
- Notify the office and complete new consent for changes in orders from the child's health care provider.
- Authorize the staff to communicate with the primary care provider/specialist regarding their medical condition as needed.
- Bonhomme Staff or Volunteers interacting directly with my child may be informed about his/her special needs while at Bonhomme Church.

Required Signatures

Parent/Legal Guardian _____ Date _____

Physician _____ Date _____