



Adventure Club Allergy Plan

Child's Name: _____ Age: _____ Grade: _____

Date of Birth: _____ Adventure Club Site: _____

Allergy:

Triggers:

Avoidance Techniques:

Symptoms of allergic reaction (check all that apply):

Mouth:	<input type="checkbox"/>	Itching	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	Swelling of Lips, Tongue, Mouth
Skin:	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Itchy Rash	<input type="checkbox"/>	Swelling of Face or Extremities
Gut:	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Nausea, Abdominal Cramps
Throat:	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Hacking Cough	<input type="checkbox"/>	Difficulty Swallowing
Lungs:	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Repetitive Cough	<input type="checkbox"/>	Shortness of Breath
Heart:	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Pale / Blueness	<input type="checkbox"/>	Change in Pulse / Blood Pressure

Other:

Procedures for responding to allergic reaction:

Medication: _____ Dosage: _____

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Doctor's contact information:

Name: _____ Phone: _____

Parent Signature: _____ Date: _____