



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Food Allergy Statement & Medical Emergency Plan

Name of Child: _____ Date of Birth ____ / ____ / ____

Name of Parent/Guardian: _____ Phone: _____

Asthma Yes No

Non-Food Allergy(s) _____

Food Allergies _____

Other _____

Signs of an allergic reaction

Systems:

Symptoms:

- Mouth Itching & swelling of the lips, tongue or mouth
- Throat Itching and/or a sense of tightness in the throat, hoarseness & hacking cough
- Skin Hives, itchy rash, and/or swelling about the face or extremities
- Gut Nausea, abdominal cramps, vomiting, and/or diarrhea
- Lung Shortness of breath, repetitive coughing, and/or wheezing
- Heart "Thready" pulse, "passing-out"

Action for Minor Reaction

If symptoms(s) are: _____

Administer: _____

Medication/dose/route

Then call: Parent/Guardian and Doctor

If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

Action for Severe Reaction

If symptoms(s) are: _____

Administer: _____ **Immediately!**

Medication/dose/route

Call: 911, then Parent/Guardian, then doctor

Any other instructions:

Parent/Guardian _____ Phone _____ Cell phone _____

Parent/Guardian _____ Phone _____ Cell phone _____

Doctor _____ Phone _____

Signature of Parent/Guardian _____ Date _____

Doctor's signature (required) _____ Date _____

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