Science Discovery
UNIVERSITY OF COLORADO **BOULDER**

Allergy Care Plan

Please Note: This form should only be completed if your child has been prescribed an EpiPen and/or received an allergy diagnosis 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 30 DAYS PRIOR TO THE START OF YOUR CHILD'S PROGRAM****

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

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: UNEXPIRED 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 Phone Number
(A stamp is acceptable if title is present)

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