



ANAPHYLAXIS MANAGEMENT PLAN

*This record is to be completed by parents or guardians in consultation with their child's doctor
EpiPen must be within its use by date and provided in a cool bag*

Child's first name:	
Child's last name:	
Date of birth:	
Age:	
Parent/ guardian's full name:	

ANAPHYLAXIS MANAGEMENT

Known Severe Allergies	
Known Triggers	

ANAPHYLACTIC REACTION

What happens before reaction?	What happens during reaction?	What happens after reaction?

Any other information that will assist with allergy management for the child while on camp.

Parent/Guardian Name: _____
Parent/guardian signature: _____
Date: _____