Nature Vision Emergency Health Plan for Allergic Reactions

Participant's Name: ____D.O.B:______________

Asthma: Yes*◯ No ◯ *High risk for severe reaction

ACTION FOR MINOR REACTION

If symptom(s) are: ____

◘ Administer: ____

Medication/dose/route

◘ Then call: Parent/Guardian/Other Emergency Contact and Doctor

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

ACTION FOR SEVERE REACTION

If symptom(s) are: ____

◘ Administer: ____IMMEDIATELY!

Medication/dose/route

◘ Call: 911 (Never hesitate to call 911)

◘ Call: Parent or Guardian

◘ Call: Doctor

I/WE HAVE READ AND UNDERSTAND THE EPIPEN MEDICATION POLICY AND AGREE TO UPDATE THIS FORM IF MY/OUR CHILD'S MEDICAL NEEDS CHANGE.

LIMITATION OF LIABILITY AND INDEMNITY. IN CONSIDERATION OF ALLOWING MY CHILD TO PARTICIPATE IN NATURE CAMP, I KNOWINGLY RELEASE AND HOLD NATURE VISION, ITS OWNERS, EMPLOYEES, VOLUNTEERS AND DIRECTORS HARMLESS TO THE EXTENT PERMITTED BY LAW, FROM AND AGAINST ALL LIABILITY FOR LOSS, INJURY, OR ILLNESS TO MY CHILD RESULTING FROM HIS/HER PARTICIPATION IN NATURE CAMP. I AGREE TO INDEMNIFY NATURE VISION, ITS OWNERS, EMPLOYEES, VOLUNTEERS AND DIRECTORS FROM ALL COSTS AND EXPENSES WHICH IT OR THEY MAY INCUR DUE TO CLAIMS OR DEMANDS ALLEGING SUCH A LOSS OR INJURY, INCLUDING SETTLEMENT PAYMENTS, COURT JUDGMENTS AND REASONABLE LEGAL DEFENSE FEES. I AGREE THAT NATURE VISION SHALL HAVE FINAL AUTHORITY REGARDING THE DEFENSE AND SETTLEMENT OF CLAIMS OR SUITS BROUGHT AGAINST IT OR ANY OF ITS OWNERS, EMPLOYEES, VOLUNTEERS OR DIRECTORS, CLAIMING ANY SUCH LOSS OR INJURY.

______________ (Parent/Guardian Initials)

______________ (Parent/Guardian Initials)

Your initials and signature signifies that you are over the age of 18 and that you have read and agree to the above on behalf of yourself and your child.

Parent/Guardian Signature: _______________________________ Date: _______________

Parent/Guardian Signature: _______________________________ Date: _______________

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 and 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”

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Additional Emergency Contacts

1. ____

Relation: ____________________ Phone _____2nd Phone____________________

2. ____

Relation: ___________________ Phone _____ 2nd Phone____________________

3. ____

Relation: ____________________Phone _____2nd Phone____________________

EPIPEN® and EPIPEN® Jr. Directions

1. Pull off gray activation cap.

2. Hold black tip near outer thigh (always apply to thigh).

3. Place firmly against thigh and press until Auto-injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.