FOOD ALLERGY ACTION PLAN

In an effort to provide the safest dining experience for the campers, we abide by this policy to accommodate kids who have dietary allergies.
If your child has dietary allergies, we ask that you take the following steps.

1. **It is mandatory that your child's RN/NP/MD complete the Colorado Allergy and Anaphylaxis Emergency Care Plan and note all dietary allergies before your child can attend camp.**
2. A menu can be requested after May 1st. We ask that parents view the menu and provide alternatives to foods their camper cannot have.
   In order to ensure safety, we also ask that families who are providing food prepare the components of the meal as much as possible prior to their arrival at camp. We will have a microwave, toaster, refrigerator and freezer available for cooking and storing food items at Base Camp. Please label each container with the camper's name and meal it is replacing so that it can be prepared for them to eat. When on trail, Beyond Timberline campers with allergies will have their food cooked on a separate cook set.
3. Fill out the chart below so our kitchen staff can follow along as the week progresses.
4. Please bring this form with you on Opening Day. We ask that you also discuss your camper's allergy/restrictions with the kitchen staff upon arrival.
5. Camp Timberline opens a Snack Shack daily to campers and this store sells various candy, ice cream, and soft drink items. If your child is allergic to items sold at the Snack Shack, we ask that parents/guardians review the store with their child to discuss what can and cannot be eaten.
6. If you should need further assistance, wish to speak to someone regarding your child's allergies, or would like the menu, please email kitchen@camptimberline.com.

Camper Name:____________________________________

Dietary Allergy(ies):____

Day	**Breakfast**	**Lunch**	**Dinner**
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

TO BE COMPLETED BY THE FOOD SERVICE TEAM:

Camper's Cabin/Group: ______________________________________

Assigned Counselor(s): __________________________________

See Next Page for Allergy Emergency Care Plan >

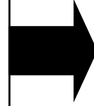
Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

Student's Name: ______________________ D.O.B. __________ Grade: ____________
School: ______________________ Teacher: ______________________
ALLERGY TO: ____
HISTORY: ____
____
Asthma: ☐ YES (higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT

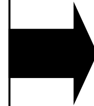
SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy,
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting, severe diarrhea
- OTHER: Feeling something bad is about to happen, confusion



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort



1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. Follow directions in above box

<u>DOSAGE:</u> **<u>Epinephrine</u>**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____minutes or more, or symptoms return, 2nd dose of epinephrine should be given

Antihistamine: (brand and dose)____

Asthma Rescue Inhaler: (brand and dose)____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) ______________________________ Phone Number: ______________

Provider's Signature: ______________________________ Date: ______________

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: ______________________ Phone Number: ______________________
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. ______________________ 1) ______________ 2) ______________
   b. ______________________ 1) ______________ 2) ______________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: ______________________________ Date: ______________

School Nurse: ______________________________ Date: ______________