YMCA OF METROPOLITAN CHICAGO
SPECIAL MEDICAL INFORMATION
SEVERE ALLERGY & ANAPHYLAXIS EMERGENCY PLAN

PARTICIPANT INFORMATION (PLEASE PRINT)		
Child's First Name:		Child's Preferred Name:
Child's M.I.	Child's Last Name:	Birthdate: ____/____/____
Allergy to:		Asthmas: ☐ Yes (higher risk for a severe reaction) ☐ No

PLEASE NOTE: It is generally recommended not to depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction, but instead to USE EPINEPHRINE. If epinephrine is administered, the YMCA will call 911 immediately.

Extremely Reactive

☐ If this box is checked, even if mild symptoms occur after a sting or eating these foods, the YMCA will give epinephrine.

For Mild to Moderate Reaction, please choose below:

The medication given is to be determined by physician authorizing treatment.

NO SYMPTOMS: If a food allergen has been ingested, but no symptoms give: ☐ Epinephrine ☐ Antihistamine	**LUNG:** If shortness of breath, repetitive coughing, or wheezing give: ☐ Epinephrine ☐ Antihistamine
MOUTH: If itching, tingling, or swelling of lips, tongue or mouth give: ☐ Epinephrine ☐ Antihistamine	**NOSE:** If itchy or runny nose and sneezing give: ☐ Epinephrine ☐ Antihistamine
SKIN: If hives, itchy rash, swelling of face or extremities give: ☐ Epinephrine ☐ Antihistamine	**HEART:** If thready pulse, low blood pressure, faint, pale or blueness give: ☐ Epinephrine ☐ Antihistamine
GUT: If nausea, abdominal cramps, vomiting or diarrhea give: ☐ Epinephrine ☐ Antihistamine	**OTHER:** Please Specify: _____ ☐ Epinephrine ☐ Antihistamine
THROAT: If tightening of throat, hoarseness or hacking cough give: ☐ Epinephrine ☐ Antihistamine	**COMBINATION:** If symptoms from the different body areas above give: ☐ Epinephrine ☐ Antihistamine

If reaction is progressing and symptoms are becoming more severe, give: ☐ Epinephrine ☐ Antihistamine
This participant recognizes the onset of an allergic reaction and can notify a YMCA member if symptoms occur. ☐ Yes ☐ No
This participant does not recognize and report the onset of an allergic reaction. ☐ Yes ☐ No
This participant is trained to administer his/her own epinephrine injection. ☐ Yes ☐ No

Parent/Guardian Signature: _____	Date: ____/____/____

Additional Information: _____