Day and Evening Camp 2019
Specialized Health Care Form

Allergy and Epi-Pen

Must be completed for campers bringing an **EpiPen** to camp.
Parent/guardian and **physician** signature required.

Camper's Name: _____
Date of Birth: _____/_____/_____ Age: _____
Address: _____
Name of Camp: _____
Program: _____ Session: _____
☐ Camper is attending more than one Sleep Away Camp program this summer.

The camper listed above is allergic to: _____
Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten/contacted, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten/contacted, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
Of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
   - Consider giving additional medications following epinephrine:
     - » Antihistamine
     - » Inhaler (bronchodilator) if wheezing
   - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
   - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
   - Alert emergency contacts.
   - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild runny nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATION SEQUENCE

If camper takes more than one medication, list sequence in which medications are to be taken:

____ Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

____ Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

____ Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

Adapted from the FOOD ALLERGY RESEARCH & EDUCATION (FARE) EMERGENCY CARE PLAN 2017

Day and Evening Camp 2019: Specialized Health Care Plan: Allergy and Epi Pen

Medication Authorization

Necessary for ALL prescription and Non-prescription medications administered at camp

Medication Name: ☐ Prescription ☐ Non ☐ **EMS**	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose::	Relevant side effects: (Specify) ☐ none expected

Medication Name: ☐ Prescription ☐ Non ☐ **EMS**	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose::	Relevant side effects: (Specify) ☐ none expected

Medication Name: ☐ Prescription ☐ Non ☐ **EMS**	Dosage/Strength:	Type of Device:
Time Given: (For what symptoms)	Time Interval/ Repeating Dose::	Relevant side effects: (Specify) ☐ none expected

Medication shall be administered during the year in which this form is dated below, unless more restrictive dates are specified here: From: _____/____/_______ To: _____/____/_______ *(This authorization is not to exceed 1 YEAR.)*

Authorization for Administration of Emergency Medication

Please note the prescriber, the parent/guardian and the Camp Health Staff must authorize self-administration. Additionally, while at camp, all emergency medications will remain with a counselor, in the camper's unit/group's first aid kit and available to the camper at all times. Epinephrine auto-injectors may be administered by unlicensed camp staff that are trained by the Camp Health Manager or through a National certification course (Red Cross).

Health Care Provider Authorization (*REQUIRED*): *I authorize the administration of the medications as ordered above.*

PRESCRIBER'S SIGNATURE * *	DATE
PRESCRIBER'S NAME AND TITLE	PRESCRIBER'S PHONE
PRESCRIBER'S ADDRESS	
"I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer."	SELF-ADMINISTER EMS MEDICATIONS ☐ Yes ☐ No

Parent/Guardian Authorization

I hereby authorize the camp staff to administer the treatments, procedures and medications or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I hereby release Girl Scouts Nation's Capital, their agents, and employees from any liability that may result from my child taking the prescribed medication. I understand that I must provide all medications/devices enclosed in this plan and that at the end of the authorized period an authorized individual must pick up the medication/devices; otherwise, it will be discarded.

PARENT/GUARDIAN SIGNATURE	DATE
"I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer."	SELF-ADMINISTER EMS MEDICATIONS ☐ Yes ☐ No

I have reviewed the camper's plan for completeness and have consulted the camper's parent/guardian, authorized prescriber, and/or the camp's health director for further questions and consultation if needed.

Camper may self-administer the above listed medication with in camp ☐ Yes ☐ No

Camp Health Staff:____ Date _______________