Sleep Away Camp 2017

Specialized Health Care Form

Must be completed for campers bringing an **EpiPen** and/or **inhaler** to camp and for campers with **diabetes**. **See both sides.**
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 foods: _____
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, 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, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

Permission for self-carry? ☐ Yes ☐ No If yes, complete this box.

Authorization for Self-Carry and Self-Administration

This portion to be completed **only if camper is to self-carry/self-administer** the medication(s) listed on this form while at camp. Self-carry/self-administration of **emergency** medication may be authorized by the prescriber and must be approved by the Camp Health Staff according to the State medication policy.

List emergency medications approved for self-carry/self-administration: _____
Parent approval for self-carry/self-administration of emergency medication: _____ Date: _____
Physician's signature self-carry/self-administration of emergency medication (**required**): _____ Date: _____
Camp Health Staff approval for self-carry/self-administration of emergency medication: _____ Date:_____

Please complete this form in Camp Docs

before April 1, 2017

I understand that I must supply the medication/supplies/equipment that is listed above. I hereby authorize the treatment and procedures described above to be administered by Camp Staff. I understand that I and /or my physician will be called if a question arises about my daughter's procedure.

Parent/guardian signature:_____ Date _____
Physician's signature (**required**): _____ Date _____

If your camper's health form is not received by April 1, her Camp registration will be canceled. Please also complete other side, if applicable.

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Address: _____

Name of Camp: _____

Program: _____ Session: _____

☐ Camper is attending more than one Sleep Away Camp program this summer.

Asthma Action Plan

Please complete this section if you camper is bringing an **inhaler** to camp.

Triggers: _____

Name of medication and strength: _____ Type of device: _____

Time(s) medication is given and time interval for repeating dose: _____

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

_____

Diabetes Action Plan

Please complete this section if your camper has **diabetes.**

When does your camper check blood sugar (BS)? _____

What is your camper's usual range of BS readings? _____

Will your camper be using an insulin pump while at camp? ☐ Yes ☐ No

If yes, what is the brand, model and model number of the insulin pump? _____

If yes, how long was your camper been using her pump? _____

Please contact GSCNC for a more detailed diabetes action plan, including readings, meals, and reactions.

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