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.

Date of Birth://	Age:
Address:	
Name of Camp:	
Program:	Session:

Parent/gu	ardian and physician signature required.		
The camper liste	ed above is allergic to:		
Weight:	lbs.	Asthma: ☐ Yes (higher risk for a severe reaction)	□ No
<u> </u>		, ,	
	tive to the following foods:		
Extremely react		NY symptoms if the allergen was likely eaten.	

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



Many hives over

body, widespread

redness



LUNG Short of breath, wheezing. repetitive cough



Repetitive

diarrhea



THROAT Tight, hoarse, trouble



tongue and/or lips

from different

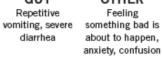
body areas.

MOUTH Significant swelling of the

breathing/ swallowing









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2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

INJECT EPINEPHRINE IMMEDIATELY.

- 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 main in ED for at least 4 hours because symptoms may return

MILD SYMPTOMS





Itchy mouth





Itchy/runny nose. sneezing

A few hives, mild itch

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):	

remain in Ery for at least 4 hours because symptoms may return.	
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-administrati 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:	on of
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	<u>::</u>

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

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

	Asthma Action Plan	
Please complete this section if you camper is bri	nging an inhaler to camp.	
Triggers:		
Name of medication and strength:	Type of device:	
Time(s) medication is given and time interval for	r repeating dose:	
If camper is taking more than one medication, li	st 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 reading	gs?	
Will your camper be using an insulin pump while	e at camp? □ Yes □ No	
If yes, what is the brand, model and mo	odel number of the insulin pump?	
If yes, how long was your camper been	using her pump?	
Please contact GSCNC for a more detailed diabe	etes action plan, including readings, meals, and reaction	ons.
Authorizat	tion for Self-Carry and Self-Administration	
, , , , , , , , , , , , , , , , , , , ,	If-administer the medication(s) listed on this form while at camp. Some must be approved by the Camp Health Staff according to the Staff	**
ist emergency medications approved for self-car	ry/self-administration:	
arent approval for self-carry/self-administration	of emergency medication:	Date: _
hysician's signature self-carry/self-administration	n of emergency medication (required):	Date: _
	ninistration of emergency medication:	5 .

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:___

Physician's signature (required): ____