

Day and Evening Camp 2021 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 nose 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): _____

Day and Evening Camp 2021: Specialized Health Care Plan: Allergy and Epi Pen

Medication Authorization

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

Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS		Dosage/Strength:		Type of Device:	
Time Given: (For what symptoms)		Time Interval/ Repeating Dose::		Relevant side effects: (Specify) <input type="checkbox"/> none expected	
Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS		Dosage/Strength:		Type of Device:	
Time Given: (For what symptoms)		Time Interval/ Repeating Dose::		Relevant side effects: (Specify) <input type="checkbox"/> none expected	
Medication Name: <input type="checkbox"/> Prescription <input type="checkbox"/> Non <input type="checkbox"/> EMS		Dosage/Strength:		Type of Device:	
Time Given: (For what symptoms)		Time Interval/ Repeating Dose::		Relevant side effects: (Specify) <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____