

Day and Evening Camp 2022

Specialized Healthcare Form **Asthma Action Plan**

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

We will also accept copies of current, physician approved action plans from camper's school/daycare

Camper's Name: _____

Date of Birth: ____/____/____ Age: _____

Address: _____

Name of Camp: _____




Program: _____ Session(s): _____

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

Healthcare Provider/ Medical Prescriber MUST complete BOTH sides of Form.

Category of Severity Mild Moderate Severe Exercise-Induced

Asthma Triggers (list things that make your asthma worse):

| Green Zone: GO! | Take these CONTROL (PREVENTION) Medicines EVERY Day | | | | | | | | | | | | | | |
|---|---|--|--|------------|-----------------------------|---|---|--|--|--|--|--|--|--|--|
| <p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can walk and play Can sleep all night <div style="text-align: center; margin-top: 10px;">  </div> | <p><input type="checkbox"/> Control Medication Required: <input type="checkbox"/> No control medicines required.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">MEDICATION</th> <th style="width: 20%;">HOW MUCH</th> <th style="width: 20%;">HOW OFTEN/WHEN</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p><input type="checkbox"/> (Montelukast) Singular, take _____ by mouth once daily at bedtime.</p> <p>For Asthma with exercise, ADD: _____, _____ puffs, _____ minutes before activity</p> <p><input type="checkbox"/> with all activity <input type="checkbox"/> when the child feels he/she needs it.</p> <p>Can be repeated in _____ hours. If symptoms occur with exercise, follow yellow zone.</p> | | | MEDICATION | HOW MUCH | HOW OFTEN/WHEN | | | | | | | | | |
| MEDICATION | HOW MUCH | HOW OFTEN/WHEN | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Yellow Zone: CAUTION! | Continue CONTROL Medicines and ADD RESCUE Medicines | | | | | | | | | | | | | | |
| <p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze, noisy breathing Vomiting after coughing Tight chest Problems sleeping or playing Reaction to asthma trigger <div style="text-align: center; margin-top: 10px;">  </div> | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">MEDICATION</th> <th style="width: 25%;">HOW MUCH</th> <th style="width: 50%;">HOW OFTEN/WHEN</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> Rescue Medicine(s): <input type="checkbox"/> Nebulizer <input type="checkbox"/> Mask <input type="checkbox"/> Spacer <input type="checkbox"/> Inhaler </td> <td style="vertical-align: top;"> Take _____ puffs of metered dose inhaler _____ Nebulizer Treatment(s) </td> <td style="vertical-align: top;"> Stay with child and keep child quiet for 15 minutes. The child should feel better within 20–60 minutes. If symptoms do not improve in _____ minutes, <input type="checkbox"/> May repeat rescue medicine ONCE <input type="checkbox"/> Staff should consult the health care provider and parent/guardian. <input type="checkbox"/> Follow the RED ZONE procedure. </td> </tr> </tbody> </table> <p>NOTE: If child uses rescue medicine >2 per week, notify the parent/guardian.</p> | | | MEDICATION | HOW MUCH | HOW OFTEN/WHEN | Rescue Medicine(s): <input type="checkbox"/> Nebulizer <input type="checkbox"/> Mask <input type="checkbox"/> Spacer <input type="checkbox"/> Inhaler | Take _____ puffs of metered dose inhaler _____ Nebulizer Treatment(s) | Stay with child and keep child quiet for 15 minutes. The child should feel better within 20–60 minutes. If symptoms do not improve in _____ minutes, <input type="checkbox"/> May repeat rescue medicine ONCE <input type="checkbox"/> Staff should consult the health care provider and parent/guardian. <input type="checkbox"/> Follow the RED ZONE procedure. | | | | | | |
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| Red Zone: DANGER! | Get Help from Doctor | | | | | | | | | | | | | | |
| <p>You have ANY of these:</p> <ul style="list-style-type: none"> Medicine is not helping Breathing is hard and fast Blue lips and fingernails Trouble walking or talking Constant cough <div style="text-align: center; margin-top: 10px;">  </div> | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">MEDICATION</th> <th style="width: 50%;">HOW MUCH and HOW OFTEN/WHEN</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> Rescue Medicine(s): <input type="checkbox"/> Nebulizer <input type="checkbox"/> Mask <input type="checkbox"/> Spacer <input type="checkbox"/> Inhaler </td> <td style="vertical-align: top;"> Take _____ puffs of metered dose inhaler every _____ minutes, for _____ treatments. _____ Nebulizer Treatment(s), every _____ minutes, for _____ treatments. Other: _____ </td> </tr> </tbody> </table> | | | MEDICATION | HOW MUCH and HOW OFTEN/WHEN | Rescue Medicine(s): <input type="checkbox"/> Nebulizer <input type="checkbox"/> Mask <input type="checkbox"/> Spacer <input type="checkbox"/> Inhaler | Take _____ puffs of metered dose inhaler every _____ minutes, for _____ treatments. _____ Nebulizer Treatment(s), every _____ minutes, for _____ treatments. Other: _____ | | | | | | | | |
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Call Parent. If not better, call doctor. If in severe distress call 911

CAMP HEALTH STAFF REVIEW

| | |
|---------------------------------------|---|
| Health Staff Comments: | Name: _____ Title: _____ Signature: _____ Date: _____ |
|---------------------------------------|---|

Adapted from Asthma Action Plan's from the Virginia Asthma Coalition (2015) and Albemarle Pediatric Asthma Coalition (2009)

Day and Evening Camp 2022: Specialized Health Care Plan: Asthma Action Plan 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.

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 |