girl scouts nation's capital

Day and Evening Camp 2023

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

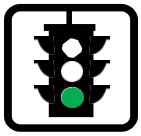
Asthma Triggers (list things that make your asthma worse):

_____

Green Zone: GO!

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can walk and play
- Can sleep all night



Take these CONTROL (PREVENTION) Medicines EVERY Day

☐ Control Medication Required: ☐ **No control medicines required.**

MEDICATION	HOW MUCH	HOW OFTEN/WHEN

☐ (Montelukast) Singular, take _____ by mouth once daily at bedtime.

For Asthma with exercise, ADD: _____, _____ puffs, _____ minutes before activity

☐ with all activity ☐ when the child feels he/she needs it.

Can be repeated in _____ hours. If symptoms occur with exercise, follow yellow zone.

Yellow Zone: CAUTION!

You have ANY of these:

- Cough or mild wheeze, noisy breathing
- Vomiting after coughing
- Tight chest
- Problems sleeping or playing
- Reaction to asthma trigger

Continue CONTROL Medicines and ADD RESCUE Medicines

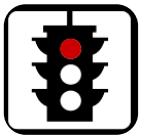
MEDICATION	HOW MUCH	HOW OFTEN/WHEN
Rescue Medicine(s): ☐ Nebulizer ☐ Mask ☐ Spacer ☐ Inhaler	Take _____ puffs of metered dose inhaler ____ Nebulizer Treatment(s)	Stay with child and keep child quiet for 15 minutes. The child should feel better within 20–60 minutes. If symptoms do not improve in _____ minutes, ☐ May repeat rescue medicine ONCE ☐ Staff should consult the health care provider and parent/guardian. ☐ Follow the RED ZONE procedure.

NOTE: If child uses rescue medicine >2 per week, notify the parent/guardian.

Red Zone: DANGER!

You have ANY of these:

- Medicine is not helping
- Breathing is hard and fast
- Blue lips and fingernails
- Trouble walking or talking
- Constant cough



Get Help from Doctor

MEDICATION	HOW MUCH and HOW OFTEN/WHEN
Rescue Medicine(s): ☐ Nebulizer ☐ Mask ☐ Spacer ☐ Inhaler	Take _____ puffs of metered dose inhaler every _____ minutes, for _____ treatments. ____ Nebulizer Treatment(s), every _____ minutes, for _____ treatments. Other: _____

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 2023: Specialized Health Care Plan: Asthma Action Plan

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.

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**