MEDICATION POLICIES & FORMS 2017

PLEASE READ CAREFULLY & Complete all necessary forms

Please note that all forms must be properly completed and signed by physician prior to first day of camp!

If at all possible, alternative plans should be made to avoid the administration of medication at camp. If you have discussed alternatives with your physician and find that medication during camp is necessary, the following procedures will be observed at Annmarie:

EMERGENCY MEDICATION AUTHORIZATION & CARE PLAN

In the event that your child should require the use of **emergency medication** (epi-pen, inhaler, etc.) while attending an Annmarie camp, **the following documents MUST be properly completed and provided PRIOR to the first day of camp:**

- **MEDICATION ADMINISTRATION AUTHORIZATION FORM** with physician signature for each medication.
- **A COMPLETED CARE PLAN must accompany each medication** addressing your child's particular need – food allergy, asthma, diabetes, etc. For your convenience, examples of common CARE PLANS are included with this packet.

**** BOTH FORMS listed above MUST be completed and signed by physician PRIOR to your child's first day of camp ****

SPECIAL NOTE: By completing the above forms and signing the attached liability release, parent/guardian gives full and unqualified permission for Annmarie staff or agents to administer the emergency medication. Further, parent/guardian understands that there is no nurse or doctor on duty at Annmarie and the Annmarie staff will call 911 and seek medical assistance in the event of an emergency.

OTHER PHYSICIAN PRESCRIBED MEDICATIONS (excluding emergency medication – see above section)

****Campers under the age of 12**-- are not permitted to self-administer medication. Camp staff will not accept or administer medication for any camper under the age of 12, aside from emergency medication (see above). Parent/Guardian will need to make arrangements to personally administer medication to their child during camp.

****Campers ages 12 & up**-- must be able to understand dosage and self-administer medication. Camp Staff may assist in storing, retrieving, and returning medication to storage area. Medication must be ordered by a physician and be in original container, with original label and prescription information; placed in a zip lock baggie with campers name written in permanent black marker on baggie. **Parent/guardian must also complete and return the MEDICATION ADMINISTRATION AUTHORIZATION FORM (with physican signature) on or before the first day of camp.** A copy of this form is included in packet. When not being used, all medication will be stored in a secure unrefrigerated cabinet in the Studio School building; when campers leave the building, any necessary medications will be carried by Camp Staff in a Backpack. Medications that require refrigeration cannot be accommodated.

CHECK LIST for camper that requires emergency medication . . .

You and your physician MUST complete the following forms PRIOR to first day of camp:

- **MEDICATION ADMINISTRATION AUTHORIZATION FORM** for each medication.
- A **CARE PLAN** must accompany each medication form.

For campers age 12 & older

Campers ages 12 & up can self-administer medication as long as physician has completed **MEDICATION ADMINISTRATION AUTHORIZATION FORM** & the **CARE PLAN.** The forms must clearly approve medication for self-administering. Campers who arrive at camp without the proper forms will not be allowed to remain.

Any unauthorized medications found on a camper will be confiscated; parents will be notified immediately. Confiscated d medications will be sent to the office where parents will be required to collect it.

QUESTIONS? Please contact Stacey Hann-Ruff, *Executive Director*, 410-326-4640 or director@annmariegarden.org

EACH medication requires this form to be completed and signed by physician. Each medication must be accompanied by a care plan. Sample care plans are attached, or you may use your own.

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. CAMP OPERATOR

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An adult must bring the medication to the camp and give the medication to an adult staff member.**

II. CAMP INFORMATION

YOUTH CAMP NAME		
PHYSICAL ADDRESS		
CITY	STATE	ZIPCODE

III. PRESCRIBER'S AUTHORIZATION

CHILD'S NAME		DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE	ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
MEDICATION SHALL BE ADMINISTERED *(NOT TO EXCEED 1 YEAR)*	FROM	TO

PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	
PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*			DATE

IV. PARENT/GUARDIAN AUTHORIZATION

I request authorized youth camp operator/staff to administer the medication as prescribed by the above 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 understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE

This is a two-page SAMPLE care plan for food allergy.
You may use your own care form, but it must be completed and signed by physican.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] 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): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

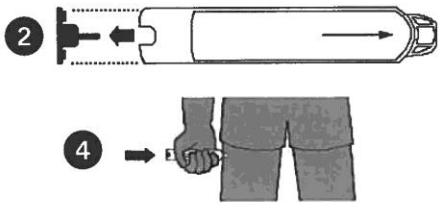
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

This is page two of a SAMPLE care plan for food allergy.
You may use your own care form, but it must be completed and signed by physician.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

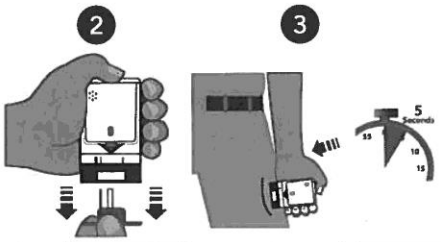
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

This is a SAMPLE asthma care plan.

You may use your own care form, but it must be completed and signed by physician.

Asthma Action Plan for:_____ Grade:_____

Date of Birth: _____ Personal Best Peak Flow:_____ Date:_____

For School Age Children K-12

WHAT TO DO WHEN YOU HAVE SYMPTOMS

GREEN ZONE

GOOD!

Look For These Signs

- No cough, wheeze, or difficulty breathing
- Can sleep through the night
- Can do regular activities

What You Should Do

- Take your **DAILY CONTROLLER MEDICINES**
- Exercise regularly
- Medicine to take before exercise: _____
- Avoid your triggers:
  Tobacco smoke
  _____
  _____
- Notes: _____
  _____

PEAK FLOW _____ — _____

YELLOW ZONE

CAUTION!

Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough more than 2 times a month
- Can't do regular activities
- Using quick relief medicine more than 2 times a week (not counting use before exercise)

What You Should Do

- Keep taking your daily controller medicine
- Begin using **QUICK RELIEF MEDICINE** every 4-6 hours as prescribed (Prime it first, if needed)
- Notes: _____
  _____
- If not better in 24-48 hours, call your doctor or nurse!
- If at school, call parent

PEAK FLOW _____ — _____

RED ZONE

DANGER!

Look For These Signs

- Very short of breath
- Hard time walking or talking
- Skin around neck or between ribs pulls in
- Quick relief medicine not helping

What You Should Do

- Get help now
- Take a nebulizer treatment
  OR
  Take 4 puffs of quick relief medicine now

CALL YOUR DOCTOR OR NURSE NOW!

OR

Go to the Emergency Room or Call 911

PEAK FLOW less than _____

MEDICINES

Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

DAILY CONTROLLER MEDICINE	HOW MUCH	HOW OFTEN	
☐ Pulmicort Respules			____times/day
☐ Pulmicort Flexhaler		____puffs	____times/day
☐ Flovent		____puffs	____times/day
☐ Singulair			At bedtime
☐ Asmanex		____puffs	At bedtime
☐ Symbicort		2 puffs	2 times/day
☐ Advair		____puffs	2 times/day

☐ Other_____ ☐ Use Spacer

QUICK RELIEF MEDICINE

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

☐ Inhaler ☐ Nebulizer
Med:
Dose:
Frequency:

REMINDER: GET A FLU SHOT

SIGNATURES

School:_____ Phone:_____ Fax:_____

This child may carry his/her: Inhaled Asthma Medicine ☐ Yes ☐ No Epi-Pen ☐ Yes ☐ No ☐ N/A

Parent Authorizes the exchange of information about this child's asthma between the physician's office and the school nurse: ☐ Yes ☐ No

Maine law permits students to carry and use inhaled medicines and epi-pen **after** demonstrating appropriate use to the school nurse.

Please call the healthcare provider and the parent if the child is using quick relief inhaler more than 2 x per week (i.e. in excess of pre-exercise treatment)

Healthcare Provider Signature _____ **Phone** _____

School Nurse Signature _____

Parent Signature _____ **Phone** _____

Form revised 06/10
Maine Asthma Council

Physicians: Fax completed copy to school nurse

Parents: Keep this handy

This is a SAMPLE diabetes care plan.

You may use your won form, but it must be completed and signed by physician.

Safe Diabetes Camp Guide

American Diabetes Association. family link
Helping Families When They Need It Most - Every Day.

Today's Date: _____

Parent(s) Name(s): _____

Child(ren)'s Name(s): _____

Parent(s) Cell Phone Number: _____

Camp site address: 13480 Dowell Road, Dowell

Cross-streets to tell 911 operator: across from Solomons Nursing center

Camp main phone number: 410-326-4640

Location of where parent(s) will be: _____

Phone number of location where parent(s) will be: _____

Times to check blood glucose (BG): _____

Target Range: _____

High BG reading: _____

Signs of a high BG: _____

What to do when BG is high: _____

Low BG reading: _____

Signs of a low BG: _____

What to do when BG is low: _____
(Note to parent(s): list fast-acting carbs i.e., juice, gel, glucose tabs and how much to give.)

Severely Low BG reading: _____

Signs of a severely low BG: _____

What to do when child is unresponsive: _____

Location of glucagon and when to administer: _____

When to call 911: _____

Insulin Instructions. Indicate when to take insulin and how much.

_____

_____

Meal/Snack Times: _____

Food to be served: _____

Alternative Foods (if child refuses to eat): _____

High Alert Situations – ALWAYS CALL PARENT(S) IF ANY OF THE FOLLOWING OCCURS

- Child had a severe low blood glucose
- Child took insulin but refuses to eat
- Child starts to vomit
- Other situations: _____

Reminders:

- Watch for signs of low BG while playing/being active
- If you leave the house, take blood glucose checking supplies, insulin (if necessary) and snacks with you
- Always call parent(s) with any questions

STOP DIABETES®

diabetes.org/families

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