MEDICATION POLICIES & FORMS

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 physician 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 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 21202-1808  
(410) 767-8417 FAX (410) 333-8926  
Toll Free 1-877-4MD-DHMH ext. 8417

<table>
<thead>
<tr>
<th>I. CAMP OPERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>- Prescription medication must be in a container labeled by the pharmacist or prescriber.</td>
</tr>
<tr>
<td>- Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.</td>
</tr>
<tr>
<td>- An adult must bring the medication to the camp and give the medication to an adult staff member.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. CAMP INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOUTH CAMP NAME</td>
</tr>
<tr>
<td>PHYSICAL ADDRESS</td>
</tr>
<tr>
<td>CITY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. PRESCRIBER’S AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD’S NAME</td>
</tr>
<tr>
<td>CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:</td>
</tr>
<tr>
<td>MEDICATION NAME</td>
</tr>
<tr>
<td>TIME/FREQUENCY OF ADMINISTRATION</td>
</tr>
<tr>
<td>IF PRN, FOR WHAT SYMPTOMS</td>
</tr>
<tr>
<td>KNOWN SIDE EFFECTS SPECIFIC TO CHILD</td>
</tr>
<tr>
<td>MEDICATION SHALL BE ADMINISTERED (NOT TO EXCEED 1 YEAR)</td>
</tr>
<tr>
<td>PRESCRIBER’S NAME/TITLE</td>
</tr>
<tr>
<td>TELEPHONE</td>
</tr>
<tr>
<td>ADDRESS</td>
</tr>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>PRESCRIBER’S SIGNATURE (Parent cannot sign here) (ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. PARENT/GUARDIAN AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>PARENT/GUARDIAN SIGNATURE</td>
</tr>
<tr>
<td>HOME PHONE #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>PRESCRIBER’S SIGNATURE</td>
</tr>
<tr>
<td>PARENT/GUARDIAN’S SIGNATURE</td>
</tr>
</tbody>
</table>
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 physician.
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.

**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-outter 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-outter 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-outter 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: __________________________

**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: ____________________________

**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: ____________________________

**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

**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 ____________________________

---

**Classification:**

- Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

**DAILY CONTROLLER MEDICINE**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmicort Respules</td>
<td>______ times/day</td>
<td></td>
</tr>
<tr>
<td>Pulmicort Flexhaler</td>
<td>______ puffs ______ times/day</td>
<td></td>
</tr>
<tr>
<td>Rotivert</td>
<td>______ puffs ______ times/day</td>
<td></td>
</tr>
<tr>
<td>Singular</td>
<td>At bedtime</td>
<td></td>
</tr>
<tr>
<td>Asmanex</td>
<td>______ puffs At bedtime</td>
<td></td>
</tr>
<tr>
<td>Symbicort</td>
<td>2 puffs 2 times/day</td>
<td></td>
</tr>
<tr>
<td>Advair</td>
<td>______ puffs 2 times/day</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>____________________________</td>
<td></td>
</tr>
</tbody>
</table>

**QUICK RELIEF MEDICINE**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaler</td>
<td>Nebulizer</td>
<td></td>
</tr>
<tr>
<td>Med:</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Dose:</td>
<td>____________________________</td>
<td></td>
</tr>
<tr>
<td>Frequency:</td>
<td>____________________________</td>
<td></td>
</tr>
</tbody>
</table>

**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 own form, but it must be completed and signed by physician.

Safe Diabetes
Camp Guide

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

diabetes.org/families
2145-30 • Updated 10/26/12