# Quaker Ridge Resident Camper's Health Statement - To be signed by a Licensed Physician

***A copy of a physical will also suffice as long as it was done within 12 months of the departure date of your camp.***

**Camper's Name**________________________________________ **Birth Date**______________________

*This child is planning to attend a residential camp, away from his/her home and more than 15 minutes from medical care. The camp must have a Camp Healthcare Supervisor (Camp Nurse) who, as a minimum, has completed an advanced first aid course. Your response to these questions will help in the care of the child.*

**Date of last visit to physician or examination within 12 months of camp**________________________________

**Past history of serious lacerations, injuries, or illnesses:** ____________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**List any allergies:** _____________________________________________________________________

**Any drug interactions? (i.e. Penicillin)** ______________________________________________________

**Medication now being used by child or special dietary requirements:** __________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Health Statement Addendums:** *Select the statements below that apply to your camper. Each addendum requires further information and signatures. If any of these do not apply to your camper, please disregard.*

- ☐ Camper has severe allergies, is at risk for anaphylaxis, or will need to carry an epi-pen while at camp – Please see and fill out "Severe Allergy Information & Care Plan" on pg. 2
- ☐ Camper has asthma – Please see and fill out "Asthma Care Plan" on pgs. 3-4
- ☐ Camper has diabetes – Please see and fill out "Healthcare Provider Order for Student with Diabetes" on pg. 5
- ☐ Camper has an insulin pump – Please see and fill out "Healthcare Provider Order for Student with Diabetes on Pump" on pg. 6

**Physician's Statement & Signature:**

*I have examined this camper and found him/her to be in satisfactory physical condition and capable of active participation in regular camp program except as follows:* ____________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

________________________________________ ________________________________
**Signature of Physician or Nurse Practitioner** **Date**

________________________________________ ________________________________
**Printed Name of Physician or Nurse Practitioner** **Phone Number**

Address of Physician's Office: ______________________________________________________________

# Severe Allergy Information & Health Care Plan

**Name:** ___________________________________ **DOB:** __________________

| **Allergies** | **Reaction** |
|---|---|
| (food, insects, medication, etc) | (date, symptoms) |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

**Permission for camper to self-carry epi-pen?** **Yes** **No**

**Emergency Treatment**

**FOR MILD SYMPTOMS:** (several hives, itchy skin, swelling at site of sting, or suspected sting or injection)

**Treatment:**

1. Give _______________ of _______________________ by mouth.
   (dose or amount) (antihistamine)
2. Stay with the student; keep student quiet, monitor symptoms until parent/emergency personnel arrives. Watch student for more serious symptoms, listed below
3. Contact parent or emergency contact person

**FOR SEVERE SYMPTOMS/ANAPHYLAXIS**

**Treatment:**

1. Give Epinephrine immediately: EpiPen JR EpiPen TwinJect
   *(Provided by parent for use.)* *(Please circle appropriate Pen)*
2. Swing and jab firmly into outer thigh until it clicks
3. Hold in place for 10 seconds, then remove, massage area for 10 seconds
4. Call 911. This is required when an EpiPen is given.
5. Contact parents or emergency contact – Contact Nurse Consultant
6. Monitor patient and vitals.
7. ONLY one dose of Epinephrine is to be given, according to this care plan.
8. Carefully place used EpiPen back in container and give to emergency personnel.
9. Camp staff will accompany student to the hospital.

*It is understood by the parent and health care provider that the emergency plan may be carried out by personnel other than the Health Care Supervisor at Quaker Ridge Camp(i.e. counselors or other certified camp staff).*

Prescribing Provider Printed Name: ____________________________________________

Signature: ______________________________________________ Date: ____________________

Parent/Guardian Signature: ___________________________________ Date: ____________________

Health Care Supervisor: ________________________________________ Date: ____________________

# ASTHMA HEALTH CARE PLAN

**Name:** ___________________________________ **DOB:** __________________

**Triggers:** (Check those that apply to the student)

___ Exercise ___Emotions ___Cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays)

___ Colds (viral illness) ___Irritants: chalk dust, dust

___ Weather changes ___Molds ___Pollens (trees, grasses, and weeds)

___ Animal dander, type? ___ Dust and dust mites ___ Other: ______________________

**SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following**

Coughing Chest tightness Shortness of Breath Turning Blue Wheezing
Rapid, labored breathing Difficulty carrying on a conversation due to breathing problems
Shallow, rapid breathing Blueness of the fingernails and lips Decreasing of loss of consciousness
Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone

Peak Flow Meter: Yes: _____ No:_____ Spacer: Yes: _____ No: _____

**CALL 911 IF THE ABOVE SYMPTOMS OCCUR/PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS ASTHMA HEALTH PLAN**

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**Instructions for Staff:**

- Have student stop whatever they are doing
- Send the student to the infirmary when experiencing respiratory difficulty as described above

**If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:**

**Directions for self-medication:**

_____ ______ (initial if applicable) Signatures of the parent/guardian **and** the physician, indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self-medicate.

parent/ guardian physician

**"Off-Site" Activities**

- Medications and peak-flow meter MUST accompany student on all off-site activities
- A copy of this Health Care Plan and current phone numbers MUST be with the staff member
- Staff member must be instructed on proper use of asthma medications

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**Physician who should be called regarding asthma:**
Name: ______________________________________________________________

Phone: _________________________________ Fax: ________________________________

## ASTHMA HEALTH CARE PLAN

### ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

| **GREEN ZONE – Good Control** | **Treatment Plan:** |
|---|---|
| - No cough or wheeze<br>- Tolerating activity easily<br>Peak flow above: _________<br>Indicates that student's asthma is under good control. This is where he/she should be every day. | 1. Daily meds: **Circle one:**<br>Albuterol Other: _________________________<br>2. Use before exercise/daily activity: Yes ___ No ___<br>3. Other: ________________________________________ |

| **YELLOW ZONE – Worsening Asthma** | **Treatment Plan:** |
|---|---|
| - Worsening symptoms<br>- More short of breath with activity<br>- Need reliever inhaler more often than usual<br>Peak flow between ________ and _________<br>Indicates that student's asthma may flare unless additional measures are taken. | 1. Daily meds: **Circle one:**<br>Albuterol Other: _________________________<br>2. Recheck peak flow 10 minutes after treatment. May return to camp activities if symptoms or peak flow improves. Vigorous activity should be avoided. **May repeat inhaler if no improvement in 20 min:** Yes ___ No ___<br>3. Call parent to inform of situation<br>4. If student is not improving or getting worse, follow Red Zone plan. |

| **RED ZONE – Danger Zone** | **Treatment Plan:** |
|---|---|
| - Getting little relief from inhalers<br>**OR**<br>- Peak flow above: _________<br>- More breathless despite medications<br>Peak flows do not respond to reliever inhaler/nebulizer.<br>**This is the student's danger zone!** | 1. **Call parent** to inform of urgent situation<br>2. If symptoms continue to be severe and/or parents aren't available, call 911<br>3. **Urgent Medications:** _________________________<br>____________________________________________<br>(include dosage) |

As parent/guardian of _________________________, I give permission for this plan to be available for use at camp and the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.

Physician signature: _______________________________________________ Date: _______________________

Parent signature: ___________________________________________________ Date: _______________________

QRC Health Care Supervisor: ________________________________________ Date: _______________________

Student signature (if self-medicating): __________________________________ Date: _______________________

## HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES

Student ______________________ DOB ________ Camp ______________________ Grade _______

Doctor ______________________ Phone ________ ______________________ _______

**Monitor Blood Glucose** ☐ Before lunch ☐ After lunch ☐ Before PE ☐ After PE ☐ Before snack ☐ Before getting on bus/going home ☐ As needed for signs/symptoms of low or high blood glucose

Blood glucose at which parent should be notified Low <___________mg/dl and High >______________ mg/dl.

Target range for blood glucose >_________ mg/dl to <_____________mg/dl.

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**<u>Hypoglycemia</u>** Student should not be sent to office unaccompanied if symptomatic or BS less than 70 mg/dl.

- Check blood glucose - if blood glucose meters not available, treat symptoms.
- Blood glucose below ______ mg/dl and/or symptomatic Treat with 10 to 15 gram carbohydrate snack.
- Mild symptoms: Treat with juice, glucose tabs, etc. until above ____ mg/dl, then snack or lunch.
- Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above ____ mg/dl, then snack or lunch.
- Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice:
  Administer Glucagon _____ mg(s) ☐ IM if trained staff available and call 911.

**<u>Hyperglycemia</u>**

☐ Check urine ketones if blood glucose is over 300 mg/dl or with symptoms of illness/vomiting. If ketones present, call parents, provide water and student should not exercise. Student may need insulin via injection.

☐ Use insulin orders (see below) when blood glucose is ______________mg/dl.

√ Recommend student be released from camp when ketones are moderate/large or symptoms of illness in order to be treated and monitored more closely by parent/guardian.

**<u>Medication</u>**

Student is on ☐ oral diabetes medication(s) Dose: ____________________ **Times to be given** ____________________.

Student is on ☐ insulin . Type: __________ Dose: ____________________ **Times to be given** ____________________.

**Blood Glucose Correction and Insulin Dosage using (Rapid Acting) Insulin:** ____________________

Blood Glucose Range __________ mg/dl Administer __________ units
Blood Glucose Range __________mg/dl Administer __________ units
Blood Glucose Range __________mg/dl Administer __________ units
Blood Glucose Range __________mg/dl Administer __________ units and check ketones
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Blood Glucose Range __________ mg/dl Administer __________ units and check ketones

If ketones present, call parents, provide water and student should not exercise.

Carbohydrate counting __________ unit(s) of insulin per __________ grams of carbohydrate with lunch.

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☐ Parent/guardian authorized to increase or decrease correction within the following range: +/- 2 units of insulin.

☐ Parent/guardian authorized to increase or decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

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**Student's Self Care** (ability level to be determined by camp Health Care Supervisor and/or Nurse Consultant and parent with input from healthcare provider)

Totally independent management. ☐ Yes ☐ No
(if independent, complete self-management agreement)
Needs verification of blood glucose by staff. ☐ Yes ☐ No
Assist/testing to be done by trained staff. ☐ Yes ☐ No
Administers insulin independently. ☐ Yes ☐ No
Self injects with verification of dose. ☐ Yes ☐ No

Self injects with trained staff supervision. ☐ Yes ☐ No
Injections to be done by trained staff. ☐ Yes ☐ No
Self treats mild hypoglycemia. ☐ Yes ☐ No
Monitors own snacks and meals. ☐ Yes ☐ No
Independently counts carbohydrates. ☐ Yes ☐ No
Monitors and interprets urine/blood ketones. ☐ Yes ☐ No

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**SIGNATURES**

My signature below provides authorization for the above written orders and exchange of health information to assist the camp Health Care Supervisor and/or Nurse Consultant in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated camp personnel under the training and supervision provided by the Nurse Consultant. This order is for a maximum of one year.

Physician ________________________________________ Date ____________________________
Parent ________________________________________ Date ____________________________
Nurse Consultant ________________________________________ Date ____________________________
Health Care Supervisor________________________________________ Date ____________________________
Student (if self-administering)________________________________ Date ____________________________

## HEALTHCARE PROVIDER ORDER FOR STUDENT WITH DIABETES ON PUMP

Student ________________________________ DOB __________ Camp ______________________ Grade __________

Doctor ________________________________ Phone ___________

**Pump settings are established by the student's healthcare provider and should not be changed by camp staff.**

**Monitor Blood Glucose** ☐ Before lunch ☐ After lunch ☐ Before PE ☐ After PE ☐ Before snack ☐ Before getting on bus/driving home

☐ As needed for signs/symptoms of low or high blood glucose

☐ All blood sugars should be entered into pump to determine need for bolus correction.

Notify parent when blood sugar <_______or >________. Target range for blood sugar >________mg/dl to <_________.

**Hypoglycemia** Student should not be sent to office unaccompanied if symptomatic or BS < ______ mg/dl.

- Check blood glucose - if blood glucose meters not available, treat symptoms.
- Blood glucose between _______ mg/dl and/or symptomatic: Treat with 10 to 15 gm carbohydrate (juice, glucose tabs, etc).
- Mild symptoms: Treat with 10 – 15 gms carbs. (juice, glucose tabs, etc). until above ______ mg/dl, then snack or lunch.
- Moderate symptoms if unable to drink juice: Administer glucose gel. Retreat until above ______mg/dl, then snack or lunch.
- Severe symptoms which may include seizures, unconscious, unable or unwilling to take gel or juice:

  Administer Glucagon ______ mg(s) IM if trained staff available and call 911. Disconnect pump.

  **Do not bolus for carbohydrates given to treat low blood glucose** until blood glucose is > 70 mg/dl.

**Hyperglycemia**

☐ If BS >300 mg/dl with ketones or 2 consecutive unexplained BS >300 mg/dl (with or without ketones), i.e. malfunctioning pump. Student may require insulin via injection and/or new infusion site/set.

☐ First contact parent , if not available then call healthcare provider for further instructions. May need insulin via syringe.

Check ☐ Urine ☐ Blood ketones if blood glucose > ______ mg/dl

√ If ketones present, call parents, provide water and student should not exercise.

√ Recommend student be released from camp when ketones are moderate/large or symptoms of illness in order to be treated and monitored more closely by parent/guardian.

**Insulin dosing for High Blood Glucose and/or Carbs**

☐ Blood glucose correction when blood sugar >_________ and insulin dosage via syringe is only to be administered when confirmed by Health Care Supervisor and/or Nurse Consultant, parent or healthcare provider for treatment of hyperglycemia in the event of pump failure:

**Insulin – Type**:________________________

**Correction Factor**: _____unit of insulin for every _____ mg/dl in blood glucose starting at: ______________

**Insulin to Carbohydrate ratio** ___ units of insulin per ______ grams of carbohydrate.

Carbohydrate ratio for snack _____units per _____ gm of carbs ______am ______pm

Bolus for carbohydrates (or to be) eaten should occur immediately ☐ Before lunch ☐ After lunch ☐ ½ bolus before & ½ bolus after

☐ Parent/guardian authorized to increase or decrease sliding scale within the following range: +/- 2 units of insulin

☐ Parent/guardian authorized to increase of decrease insulin to carbohydrate ratio within the following range: 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

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**Student's Self Care**: (ability level determined by Health Care Supervisor and/or Nurse Consultant nurse and parent with input by healthcare provider

Independently monitors blood glucose. ☐ Yes ☐ No

(if independent, complete self-management agreement)

Self injects with verification of dosage. ☐ Yes ☐ No

Needs assistance with pump management. ☐ Yes ☐ No

Independently manages pump boluses. ☐ Yes ☐ No

Independently counts carbohydrates. ☐ Yes ☐ No

Inserts new infusion set. ☐ Yes ☐ No

Tests and interprets urine/blood ketones. ☐ Yes ☐ No

Injection to be done by trained staff ☐ Yes ☐ No

Self treats mild hypoglycemia. ☐ Yes ☐ No

**SIGNATURES**

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Physician ______________________________ Date ______________________

Parent ______________________________ Date ______________________

Nurse Consultant ______________________________ Date ______________________

Health Care Supervisor ______________________________ Date ______________________

Student (if self-administering) ______________________________ Date ______________________