Sterling House Day Camp

Medical Form Cover Sheet

Packet C

EPI-PEN

Dear Families,

Attached you will find the Emergency Health Care Plan to be filled out by your child's doctor. There is also the Medication Administration Authorization Form. Make a separate copy of this form for each medication that the doctor prescribes for your child.

This needs to be turned in AT LEAST one week before your camp session begins along with the medication(s).

Thank you,

Camp Directors & First Aid Staff

Revised 2022

Emergency Health Care Plan

ALLERGY TO: _____

Child's Name: _____ DOB: _____ Child Care Provider_____

History of Asthma ____ Yes (high risk for severe reaction) ____ No

Signs of an allergic reaction include:

Systems	Symptoms
MOUTH	Itching & swelling of lips, tongue, or mouth
***THROAT**	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
***LUNG**	Shortness of breath, repetitive coughing, and/or wheezing
***HEART**	"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION: If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)

_____ Observe child for severe symptoms
_____ Administer EpiPen® before symptoms occur
_____ Administer EpiPen® if symptoms occur
_____ Administer Benadryl® (dose)_____ or Atarax® (dose) _____
_____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
_____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!

_____ _____ _____ _____
Parent/Guardian Signature Date Prescriber Signature MD/APRN/PA Date

_____
Address Phone

EMERGENCY CONTACTS	SIGNATURES OF STAFF MEMBERS
1. _____	1. _____ Trained Y/N_____
Relation: _____ Phone _____	2. _____ Trained Y/N_____
2. _____	3. _____ Trained Y/N_____
Relation: _____ Phone _____	4. _____ Trained Y/N _____
3. _____	5. _____ Trained Y/N_____
Relation: _____ Phone _____	Health Consultant: _____ Date: _____

For children with multiple allergies, use one form for each allergen

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/____ Today's Date___/___/____

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/____

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

****

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student _____ **Date of Birth** ____/____/____

Pharmacy Name _____ **Prescription Number** _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** ____/____/____