Medical Form Packet

If your child will be taken any medication at camp or
has a medical problem that the camp nurse should be aware of,
Please complete the following forms.

Please bring forms and medicine to the camp nurse on the first day of camp.
She will be available that day starting at 8:30 a.m.

Please make sure all forms are filled out properly
and are signed by your physician.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the New Jersey State Law and Regulations require an authorized prescriber (M.D., P.A. or APRN) or dentist's written order AND parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the medication, strength, dosage, frequency, authorized prescriber or dentist's name and date or original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER:

Date of Order: _____

Name of Child: _____ Date of Birth: __/__/__

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Condition for which the medication is being administered during camp hours:

_____

Medication: Name of medication, dosage and method of administration:

_____

Times of administration: _____ Medication shall be administered from: __/__/__ through __/__/__

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled medication? _____

Allergies, reaction to, or negative interaction with food and drugs? If yes, list:

_____

AUTHORIZED PRESCRIBER'S OR DENTIST'S INFORMATION (PLEASE PRINT):

Authorized Prescriber's of Dentist's Name: _____ Telephone number: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Authorized Prescriber's or Dentist's Signature: _____ Date: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR ADMINISTRATION OF ABOVE MEDICATION

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child, _____, be administered by the nurse or camp personnel with current Medication Administration Training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following the termination of the order.

Parent/Guardian Name: _____

Relationship to Camper: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Parent/Guardian Signature: _____ Date: _____ Emergency Phone Number: _____

SELF ADMINISTERED INHALER/EPIPEN OR MEDICATION FOR LIFE THREATENING ILLNESS

This is only for life threatening illnesses, not over the counter medications!

A camper may be permitted to self-administer a medication for a life threatening allergy or illness. The parent must understand that the camp will not accept any responsibility for injury arising from the self medication and sign the following statement to that effect. I hereby give permission for my child _____, to self-administer _____, which is a medication required for the following medical condition _____. My child is capable of, and has been instructed in the proper administration of the required medication. I understand that the 4th and Inches Football Camp will not be held responsible for any injury arising from self-administration.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Asthma Treatment Plan – Camper

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION

NJ Health — New Jersey Department of Health

(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above __________

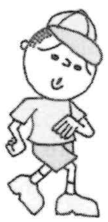
Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take ____________ ____ puff(s) minutes before exercise.

CAUTION (Yellow Zone)



You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______to______

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue
- Fingernails blue
- Other:__________

And/or Peak flow below __________

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - Dust Mites, dust, stuffed animals, carpet
  - Pollen - trees, grass, weeds
  - Mold
  - Pets - animal dander
  - Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - Cigarette smoke & second hand smoke
  - Perfumes, cleaning products, scented products
  - Smoke from burning wood, inside or outside
- ☐ Weather
  - Sudden temperature change
  - Extreme weather - hot and cold
  - Ozone alert days
- ☐ Foods:
  - __________
  - __________
  - __________
- ☐ Other:
  - __________
  - __________
  - __________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Permission to Self-administer Medication:

☐ This camper is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This camper is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE____________________ DATE________

Physician's Orders

PARENT/GUARDIAN SIGNATURE____________________

PHYSICIAN STAMP

REVISED JULY 2021

Make a copy for parent and for physician file, send original to camp nurse or Park System staff.

Asthma Treatment Plan – Camper Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual camper to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number

2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check **"OTHER" and:**
     - ✞ **Write in asthma medications not listed on the form**
     - ✞ **Write in additional medications that will control your asthma**
     - ✞ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, camp staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at camp as prescribed in the Asthma Treatment Plan. I give permission for trained Monmouth County Park System staff to administer this medication. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the camp nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with camp staff on a need to know basis.

_____ _____ _____

Parent/Guardian Signature Phone Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication_____for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current camp season as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the Monmouth County Park System, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the Monmouth County Park System, its agents and employees against any claims arising out of self-administrationor lack of administration of this medication by the camper.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

_____ _____ _____

Parent/Guardian Signature Phone Date

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
www.pacnj.org

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ALLERGY ACTION PLAN

Freehold Township Summer Camp 2022

Camper's Name: _____ Birthday: _____

ALLERGY TO: _____

Type of reaction in the past (please circle) cutaneous respiratory eye/nasal cardiac
Gastrointestinal Othe-please specify _____

Date of Reaction _____ Anaphylaxis YES ☐ NO ☐ Hospitalized YES ☐ NO ☐

If anaphylactic to a food, camper should only consume food or drinks provided by parent/guardian.

Place Child's Picture Here

Skin Testing YES ☐ NO ☐ In Vitro Testing YES ☐ NO ☐

Asthmatic *YES ☐ NO ☐ **Higher risk for severe reaction ☐ Child must wear MEDICAL ALERT bracelet

♦ STEP 1: TREATMENT ♦

Symptoms:		Give Checked Medication**:	
•	If a food allergen been ingested, but *no symptoms:*	☐ EpiPen	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
• Throat+	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
• Lung –	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
• Heart –	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
• Other –	_____	☐ EpiPen	☐ Antihistamine
•	If reaction is progressing (several of the above areas affected), give	☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. + Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

May Repeat x _____ every _____ (In absence of a nurse, a trained delegate may give epinephrine only for a multisystem reaction. Delegates may not administer antihistamine.)

Antihistamine: Give Diphenhydramine PO ☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ Other_____
Medication/route/dose

Other: _____
Medication/route/dose

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911 and state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Call Parent/Guardian _____ at _____ or _____
   _____ at _____ or _____

EVEN IF PARENT/GUARDIANCANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Doctor's Signature _____ Date _____ Office Stamp [ ]

I hereby request that the nurse administer the above medication as directed by my physician to my child. I will supply medication in the ORIGINAL CONTAINER and will notify the nurse promptly of any change in this order.

Parent/Guardian Signature _____ Date _____

Epinephrine Delegate Authorization Form

Child's Name: _____

I, _____, parent/guardian of the above named child, give authorization for a properly trained delegate to administer epinephrine via pre-filled auto injector mechanism in an emergency and/or in the event that the camp nurse is unavailable during an anaphylaxis reaction.

_____ _____
Parent/Guardian Signature Date

This authorization is valid from June 27, 2022 through August 19, 2022.

By signing this authorization, Freehold Township Parks and Recreation Summer Camp shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto injector mechanism to the above named child and that the parent/guardian shall indemnify and hold harmless Freehold Township Parks and Recreation Summer Camp and its employees or agents any claim arising out of the administration of epinephrine via a prefilled auto injector mechanism.

_____ _____
Parent/Guardian Signature Date

Refusal for Epinephrine Delegate

Child's Name: _____

I, _____, parent/guardian of the above named child waive my right to have a properly trained delegate administer epinephrine via pre-filled auto injector mechanism or the child's self –administration of epinephrine via a pre-filled auto injector mechanism as ordered by my prescriber (MD, DO, ANP).

_____ _____
Parent/Guardian Signature Date