Camper Health Form

Do you need to fill out the Health Form for your child?

- Yes, the State of Maryland requires **all** children to complete health forms for all camp facilities.
- All campers must have a completed **Renaissance Art Center Camper Health Form** (page 2)
- Deliver your completed health forms in one of the following ways:
  - Email to **office@rcarts.net**, or
  - Drop off in camp office prior to your week of camp, or
  - Hand to Renaissance Art Center staff at drop off.
  - Medication must be brought directly to the camp office (see below)

Campers with Medication, Allergies, or Asthma:

- Complete the following forms
  - **Renaissance Art Center Camper Health Form** (page 2)
  - **Medication Administration Authorization Form** (page 3)
  - **Allergies** - pages 4 and 5
  - **Asthma** - pages 6 and 7
- Provide medications, in a clear zip lock bag with your child's name neatly labeled with marker:
  - Emergency Medication with original pharmacist label or presciber prescription.
  - Non-Prescription Medication in the original container with the instructions for use.
- **Hand deliver** packed and labeled bag to our office during Monday morning camp drop off, or the week prior to camp beginning.
- Medication will be returned to:
  - Parent/guardian coming into office at the end of the camp week **(please park and walk in)**, or
  - Designated person authorized by parent/guardian. **Please provide person's name in writing**.

Information to Know:

- Monday morning is a very busy time for us. Please be patient and wait in our waiting room until we can get to you. You may drop off forms and medication the week prior to your camp start date.
- The Camp Office is located inside the main entrance. Summer office hours are Monday - Friday, 8:30 am - 5:30 pm.
- Please make sure all information is clearly labeled and easy to read.
- No child will be allowed to take prescription or over-the-counter medication during camp hours without a completed **Medication Administration Authorization Form**.
- All medications will be kept in our secure, non-refrigerated location in our office which is accessible only by authorized personnel. Exceptions where the camper would carry the medication with them at all times will be made only in extenuating circumstances and with permission from the parent and physician.
- Office staff will need to be made aware of any medication that should be returned on a daily basis. Please be sure the medication is returned to our office first thing each morning.

Renaissance ART CENTER

Camper Health Form

Camper's Name: _____ Nickname: _____

Current Reisdence: _____

Date of Birth (month/day/year): _____/_____/_____ Age at time of camp: _____

Please list all camps attending in 2018:

Camp Date:_____ AM _____ PM _____

Camp Date:_____ AM _____ PM _____

Camp Date:_____ AM _____ PM _____

Camp Date:_____ AM _____ PM _____

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact: _____ Phone: _____

Secondary Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

HEALTH INFORMATION

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐**NO**

☐**YES,** Explain: _____

_____

_____

Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐**NO**

☐**YES,** Explain: _____

_____

_____

ALLERGIES: Cause of allergy onset: _____ Should camper sit separately: _____

IMMUNIZATION INFORMATION (must list current home residence above):

Campers currently residing within the United States, a U.S. territory, or the District of Columbia: Does this camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ☐**NO**

☐**YES,** List: _____

Campers currently residing outside the United States, a U.S. territory, or the District of Columbia:

Attach record of vaccination or immunity on Department form MDH-896.

_____ _____

Parent or Legal Guardian's Signature **Date**

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

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 authorized individual must bring the medication to the camp and give the medication to an adult staff member.**

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ____/____/_____ Month Day Year
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION [ ] YES ***-If yes, see Section III below.*** [ ] NO
5. MEDICATION NAME	6. DOSE	7. ROUTE
8. TIME/FREQUENCY OF ADMINISTRATION	9. IF PRN, FREQUENCY	
10. IF PRN, FOR WHAT SYMPTOMS		
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR***.	12a. FROM ____/____/_____ Month Day Year	12b. TO ____/____/_____ Month Day Year

13. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	
14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*			14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized 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 authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15C. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE

Management of Severe Allergic Reactions & Anaphylaxis

Place photo here

Camper's Name: _____

Date of Birth (month/day/year): _____/_____/_____

ALLERGY TO: _____

Asthmatic? (Y/N): _____ (Yes = Higher Risk of Severe Reaction)

STEP 1: TREATMENT

Symptoms	Give This Medication	
	Epinephrine	Antihistamine
If a food allergen is ingestedor suspected bee sting, but no symptoms		
Mouth: itching, tingling, or swelling of lips, tongue, mouth		
Skin: hives, itchy rash, swelling of face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: tightening of throat, hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

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

DOSAGE

Epinephrine: inject intramuscularly:

EpiPen® or generic _____ EpiPen JR® or generic _____ Auvi-Q _____

Antihistamine: give: _____

Other: give: _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine may be needed.

_____ _____

Doctor's Name **Doctor's Phone Number**

_____ _____

Parent's Name **Parent's Phone Number**

_____ _____

Emergency Contact Name/Relationship **Emergency Contact Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REAHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

_____ _____

Parent/Guardian's Signature/Date **Doctor's Signature/Date**

Allergy Prevention Plan

Place photo here

Camper's Name: _____

Date of Birth (month/day/year): _____/_____/_____

ALLERGY TO: _____

Asthmatic? (Y/N): _____ (Yes = Higher Risk of Severe Reaction)

CAMP WILL:

- ☐ Have staff trained in First Aid/CPR
- ☐ Have staff trained in emergency Allergy Management and Anaphylaxis - administering EpiPen® including demonstration and practice
- ☐ Distribute Emergency List to staff
- ☐ Have staff trained on individual emergency plans
- ☐ Ensure staff make every reasonable effort to prevent camper's exposure to known allergens
- ☐ Other: _____

PARENTS WILL:

- ☐ Provide pertinent health information
- ☐ Provide Physician Authorization Forms and Action Plans - for medication and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide safe snack options to camp
- ☐ Other: _____

CAMPER WILL:

- ☐ Make every effort to avoid contact with allergen
- ☐ Alert nearest adult is suspected exposure to allergen
- ☐ Other: _____

NOTES:

_____

_____

_____

Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN ____/____/____ (Date) to ____/____/____ (Date) (not to exceed 12 months)

TRIGGER (LIST)

Child's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS / INDICATIONS FOR MEDICATION USE

GREEN ZONE

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: _____
- ☐ Peak flow greater than _____ (80% personal best)

CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

- ☐ Prior to exercise/sports/ physical education (PE)

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.

YELLOW ZONE

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: _____
- ☐ Peak flow between _____ and _____ (50%-79% personal best)

RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

Medication	Dose	Route	Frequency/Time

If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.
If using more than twice per week, notify the health care provider and parent/guardian.

RED ZONE

- ☐ Medication is not helping within 15-20 mins
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or intercostal retraction
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: _____
- ☐ Peak flow less than _____ (50% personal best) _____

EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911

Medication	Dose	Route	Frequency/Time

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911.

HEALTH CARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications ◉ Yes ○ No

Health Care Provider Name: _____

Signature: _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child ◉ is ○ is not authorized to self-carry his/her medication(s):

Signature: _____

Date: _____

Asthma Prevention Plan

Place photo here

Camper's Name: _____

Date of Birth (month/day/year): _____/_____/_____

CAMP WILL:

- ☐ Have staff trained in First Aid/CPR
- ☐ Have staff trained in Allergy and Anaphylaxis, Asthma Signs and Symptoms, and Administration of Inhaler or Nebulizer - administering EpiPen® including demonstration and practice
- ☐ Distribute Emergency List to staff
- ☐ Have staff trained on individual emergency plans
- ☐ Ensure staff make every reasonable effort to prevent camper's exposure to known allergens and Asthma triggers
- ☐ Other: _____

PARENTS WILL:

- ☐ Provide pertinent health information
- ☐ Provide Physician Authorization Forms and Action Plans - for medication and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other: _____

CAMPER WILL:

- ☐ Alert nearest adult if they experience any symptoms of Asthma (cough, wheezing, shortness of breath)
- ☐ If self-carrying and self-administering, will demonstrate responsibility by carrying inhaler and notifying an adult when they have to use it, and committed to not sharing medication with any other person.
- ☐ Other: _____

NOTES:

_____

_____

_____