Specialized Health Care Form

Camper's Name: _____

Date of Birth: _____/_____/_____ Age: _____

Address: _____ Parent Phone Number: _____

Program: _____ Session: _____

Allergy Action Plan: Please complete this section if you camper is bringing an **EpiPen** to camp.

Allergic to: _____ (if action plans differ, copy this form and use a different form for each allergy)

► If a food allergen has been ingested, but no symptoms . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Itching, tingling or swelling of lips, tongue or mouth . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Skin hives, itchy rash, swelling of the face or extremities . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Gut nausea, abdominal cramps, vomiting, or diarrhea . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Throat – tightening, hoarseness, hacking cough . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Lung – shortness of breath, repetitive coughing, wheezing . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Heart – thready pulse, low BP, fainting, pale, blueness . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► Other: _____ . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

► If reaction is progressing (several of the above areas affected) . . . . . ☐EpiPen ☐Antihistamine ☐Other: _____

Epinephrine: Inject intramuscularly ○EpiPen OR ○EpiPen Jr (circle one)

Antihistamine: Give _____, _____, _____

name of medication dose route

Other: Give _____, _____, _____

name of medication dose route

EpiPen will be carried by a counselor with the camper at all times. If possible, please bring two (2) EpiPens. The second EpiPen will be kept in the camp health center.

Asthma Action Plan: Please complete this section if you camper is bringing an **inhaler** to camp.

Triggers: _____

Name of medication and strength: _____Type of device: _____

Time(s) medication is given: Time interval for repeating dose: _____

Diabetes Action Plan: Please complete this section if your camper is diabetic.

When does your camper check blood sugar (BS)? _____

What is your camper's usual range of BS readings? _____

When does your camper inject insulin? _____

What type is used and how many units? _____

Will your camper be using an insulin pump while at camp? ☐Yes ☐No

If yes, brand, model and model number: _____

How long has your camper been using her pump? _____

Mental Health Action Plan: Please complete this section if you camper has been experiencing issues related to mental health, such as anxiety.

Triggers: _____

Medications or Coping Skills: _____

Contact information for Mental Health Provider: _____

Time(s) medication is given: Time interval for repeating dose: _____

I understand that I must supply the medication/supplies/equipment that is listed above. I hereby authorize the treatment and procedures described above to be administered by Camp Staff. I understand that I and/or my physician will be called if a questions arises about my daughter's procedure.

Parent/guardian signature: _____ Date: _____

Physician's signature **(required)**: _____ Date: _____