FOOD ALLERGIES, HEALTH CONCERNS & Emergency Action Plans

By

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FOOD ALLERGIES

- 1 in 5 Americans has some type of allergy
- 1 in 13 children in the US has food allergies (Approximately 2 per classroom)
- 1 in 4 children have their first allergic reaction at school
- Number of people worldwide with allergies is increasing with steepest increase in food allergies in children – Increased 50% between 1997 – 2011
- No cure – Just avoidance or management


Assorted
Food Coloring
& Egg Dye


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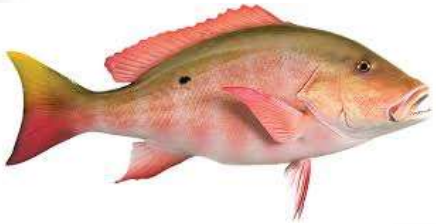
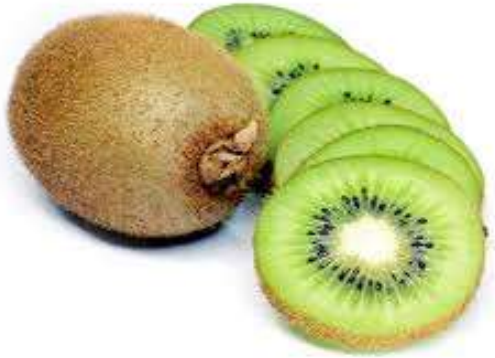




- Peanuts, tree nuts, milk, eggs, wheat, soy, fish, shellfish cause 90% of food allergic reactions in US
- Other allergens include: Latex, insects, sesame, pharmaceutical drugs, environmental factors – Not required on labels
- Cross contact/contamination
- Cross-Reactivity - Proteins in one food are similar to the proteins in another

RECOGNIZE THE SYMPTOMS

- Drippy nose, itchy eyes, dry throat, rashes and hives, nausea, vomiting, diarrhea, labored breathing, lethargy, anaphylaxis or anaphylactic shock
- Children could describe as :
  - There is a frog in my throat.
  - My lips feel tight.
  - My tongue feels full or itches.
  - My throat feels thick.
  - It feels like a bump on the back of my tongue. (or throat)

EMERGENCY PREPAREDNESS

- Create camp rules and procedures for dealing with allergies
- Be informed of the availability of emergency care
- Review the health records submitted by parents and physicians
- Provide opportunity for parents to bring in info and speak to camp personnel prior to beginning of camp
- Require emergency action plans for campers with allergies and have them easily accessible

EMERGENCY PREPAREDNESS

- Provide food allergy education to all staff
- Maintain an appropriate sense of confidentiality and respect for individual privacy.
- Identify the camp core emergency response team.
- Assure that appropriate personnel are familiar with symptoms of allergic reactions, cross contamination, cross reactivity, the use of epinephrine, temperature of epinephrine, where medication is located, and the protocols.

PREVENTION

- Read labels…if you can't read it, don't use it!
- Be aware of cross-contamination of equipment
- Only top 8 allergens are required by law to be labeled
  - Ensure food service personal are aware of top allergens, children with food allergies and cross contamination
- Prohibit trading or sharing food during lunch or snack time
- Have campers wash hands when they first get to camp
- Have campers wash hands before and after handling or consuming food (snacks/lunch)
- Clean hard surfaces in areas where food is consumed with soap and water before and after snacks or meals to remove allergens.

SOCIAL & EMOTIONAL

- Structure and plan activities so that all students with or without allergies can safely participate in all camp activities
- Allergy free tables – Be sure camper doesn't feel isolated from other students – Alternate students at table to promote social relationships
- Approximately 1/3 of all students with food allergies have been bullied
- Reinforce policies on bullying and discrimination. Teasing or taunting about a food allergy should not be permitted.

What is an Emergency Action Plan?

- Details step-by-step procedures to follow for specific emergencies.
- The purpose of an Emergency Action Plan is to facilitate and organize employer and employee actions during workplace emergencies.
- An Emergency Action Plan includes who to notify, delineates staff role and responsibilities, and location of emergency equipment/medications

FORMS
Emergency Action Plans

- Parent/caregiver must complete prior to child starting camp!!!
- MUST BE SIGNED!!!
- A child does not have to have a disability to have an Emergency Action Plan completed
- 3 main Emergency Action Plans
  1. Allergy
  2. Asthma
  3. Seizure
- Also Include:
  1. Medical Release
  2. Consent for Treatment
  3. Authorization for Medication

Allergy Action Plan

CHILD'S NAME:_____ D.O.B.:_____

TEACHER:_____

ALLERGY TO:_____

_____

ASTHMATIC ☐ yes* ☐ no *High risk for severe reaction

☑ Check signs of allergic reaction pertinent to your child

☐	MOUTH	itching & swelling of the lips, tongue or mouth
☐	THROAT	itching &/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. ☐ yes ☐ no

ACTION FOR MINOR REACTION:

1. If symptoms are:_____, give my child_____
medication/dose/route

Then call:

2. Mother_____, Father_____or emergency contact
3. Dr. _____ at _____

If condition does not improve within ten minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION:

1. If ingestion/contact is suspected and/or symptom(s) are: _____
_____ give _____ IMMEDIATELY!
medication/dose/route

Then call 911

2. Rescue Squad (ask for advanced life support)
3. Mother _____, Father _____, or emergency contact
4. Dr. _____ at _____

Parent Signature _____ Date _____

Physician's Signature _____ Date _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

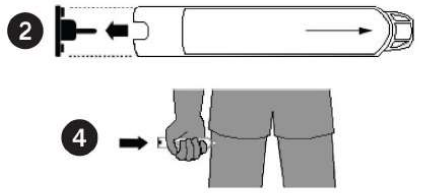
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

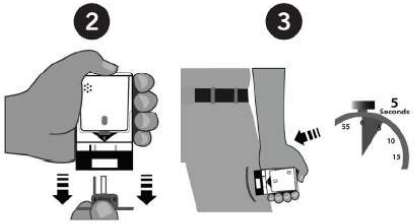
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

ASTHMA ACTION PLAN

Child Name: _____ DOB: _____ Teacher: _____

Emergency Contact: _____ Phone: _____

Severity Classification	Triggers	Exercise
☐ Mild Intermittent ☐ Moderate Persistent ☐ Mild Persistent ☐ Severe Persistent	☐ Colds ☐ Smoke ☐ Weather ☐ Exercise ☐ Dust ☐ Food ☐ Animals ☐ Air Pollution ☐ Other _____	1.Pre-medication (how much and when) _____ 2.Exercise modifications _____

GREEN ZONE: Doing Well — Peak Flow Meter Personal Best =

Symptoms
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter
More than 80% of personal best or _____

Control Medications

Medicine	How Much to Take	When to Take It

YELLOW ZONE: Getting Worse — Contact Physician if using quick relief more than 2 times per week.

Symptoms
- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter
Between 50 to 80% of personal best or _____ to _____

Continue Control Medicines and add:

Medicine	How Much to Take	When to Take It

If your symptoms (and peak flow, if used) return to Green zone after one hour of the quick relief treatment, THEN
- ☐ Take quick-relief medication every 4 hours for 1 to 2 days
- ☐ Change your long-term control medicines by _____
- ☐ Contact your physician for follow-up care

If your symptoms (and peak flow, if used) DO NOT return to GREEN ZONE after 1 hour of the quick relief treatment, THEN
- ☐ Take quick-relief treatment again
- ☐ Change your long-term control medicines by _____
- ☐ Call your physician/Health Care Provider within _____hours of modifying your medication routine

RED ZONE: Medical Alert — Ambulance/Emergency Phone Number:

Symptoms
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter
Between 0 to 50% of personal best or _____ to _____

Continue Control Medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if
- ☐ Still in the red zone after 15 minutes
- ☐ If you have not been able to reach your physician/health care provider for help
- ☐ _____

Call an ambulance immediately if the following danger signs are present
- ☐ Trouble walking/talking due to shortness of breath
- ☐ Lips of fingernails are blue

DIABETES EMERGENCY ACTION PLAN

Picture

Student Name:_____ **DOB** _____ **Grade:**_____

Parent/Guardian:_____ **Phone(s):**_____

CHECK BLOOD GLUCOSE

Below 70 (or _____) (Hypoglycemia) ONSET: Sudden		**70 – 90 or _____--_____**	**91 – 125 or ____--____**	**126 – 250 or ___--___**	**Above 250 (or _____) (Hyperglycemia)** ONSET: Over time – several hours or days	
***SEVERE HYPOGLYCEMIA** Combative Inability to swallow Unable to control airway Loss of consciousness Seizure	**MODERATE HYPOGLYCEMIA** Blurry Vision Confusion Weakness Headache Sleepiness Behavior change Poor coordination Slurred speech	**MILD HYPOGLYCEMIA** Hunger Weakness Paleness Irritability Dizziness Sweating Crying Anxiety Shakiness Headache Poor concentration Personality change Drowsiness	If exercise is planned before a snack or meal (including recess) the student must have a snack before participating.	Student is fine.	**MILD/MODERATE HYPERGLYCEMIA** Thirst Frequent Urination Stomach pains Fatigue/sleepiness Flushing of skin Increased hunger Blurred vision Lack of concentration Sweet, fruity breath Dry mouth	***SEVERE HYPERGLYCEMIA** Mild and moderate symptoms plus: Labored breathing Confused Very weak Unconscious
ACTIONS FOR SEVERE HYPOGLYCEMIA 1. Don't attempt to give anything by mouth. 2. Position on side, if possible. 3. Contact trained diabetes personnel. 4. Disconnect insulin pump. 5. Administer glucagon, if prescribed. **6. Call 911.** 7. Contact parents/guardian. 8. Stay with student.	**ACTIONS FOR MODERATE HYPOGLYCEMIA** 1. Give student fast-acting sugar source 2. Wait 10 to 15 minutes. 3. Recheck blood glucose. 4. Repeat food if symptoms persist OR blood glucose is less than 70. 5. Follow with a snack of carbohydrate and protein (e.g.,cheese and crackers).	**ACTIONS FOR MILD HYPOGLYCEMIA** If student's blood sugar result is immediately following strenuous activity, give an additional fast-acting sugar.			**ACTIONS FOR MILD/MODERATE HYPERGLYCEMIA** 1. Allow liberal bathroom privileges. 2. Encourage student to drink water or sugar-free drinks. 3. Check blood glucose & administer insulin per physician orders 4. Contact parent if blood sugar is over 300 mg/dl.	**ACTIONS FOR SEVERE HYPERGLYCEMIA** 1. If student vomits or is lethargic call parent. 2. If parent is unavailable contact 911.
Causes of Hypoglycemia: Too much insulin, missed food, delayed food, or exercise					**Causes of Hyperglycemia:** Too much food, too little insulin, illness, stress, or decreased activity	

FAST ACTING SUGAR SOURCES:

3-4 glucose tablets **OR** 4 ounces juice **OR** 6 ounces regular soda **OR** 3 teaspoons glucose gel **OR** 3 teaspoons sugar in water

Never send a child with suspected low blood glucose anywhere alone!!!

Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

***Severe symptoms are a life-threatening emergency**

Seizure Action Plan

CHILD'S NAME:_____ **D.O.B.:**_____ **TEACHER:**_____
Description of seizure condition/disorder:_____

Describe what your child's seizures look like: (1) what part of the body is affected? (2) How long does it last? _____

Describe any know "triggers" (behavior and /or symptoms) for seizure activity: _____

Detail the time and duration of child's typical seizure activity: _____

Has the child been treated in the emergency room due to seizures? ☐ yes ☐ no How many times?_____
Has the child stayed overnight in the hospital due to their seizures? ☐ yes ☐ no How many times?_____

Planned strategies to support the child's needs and safety issues when a seizure occurs:
(diapering/toileting, outdoor play, nap/sleeping, etc) _____

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn if prescribed.	Decrease possibility of injuries related to seizure activity.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Decrease possible aspiration during seizure activity.
Self esteem disturbance related to occurrence of seizure or use of protective helmet .	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any reactions. Reassure the other children in the group that the child will be all right if a seizure occurs.	Increase child's successful adaptation to requirements of living with a seizure disorder. The child will demonstrate a positive attitude Toward learning activities. Other children will feel safe.
Parent and child may not be Aware of possible triggers.	Staff will document the occurrences of any seizure activity on attached *Seizure Activity Log*	Parent, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after seizure, then will allow the child to sleep and/or rest after seizure.	The child may safely sleep/rest if needed, after seizure occurs.

Medications to be administered: ☐ yes ☐ no *specify administration method, time schedule, side effects*
Type of medication: _____

Additional Information: (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)_____

Emergency Procedure

Call 911 if: ☐ seizure is longer than _____ minutes ☐ child is unresponsive after seizure
☐ color changes ☐ other : _____

Emergency Contact: _____ Telephone:_____

This Seizure Action Plan will be updated/revised whenever medications of child's health status changes.

Parent Signature _____ **Date** _____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Medical Release

Name of Child: _____ Age: _____ Date of Birth: _____

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I/We may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give *(SITE NAME)* staff and faculty the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that *(SITE NAME)* shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Villa Lyan. I understand that this form is in effect from the date signed and that it is my responsibility to inform *(SITE NAME)* of any changes to this form.

Signature of Mother/Legal Guardian:_____ Date: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Signature of Father/Legal Guardian:_____ Date: _____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Pediatrician's Name: _____ Telephone Number: _____

Hospital Preference: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Insurance Company: _____ Policy/Group #_____

Date of Minor's Last Tetanus Shot: _____ List Current Medications: _____

Allergies: _____ _____

_____ _____

Medical history or other important fact that should be known: _____

_____

_____

Consent for Treatment

I, _____ the parent and/or guardian of
Parent/Legal Guardian Name

_____, give my consent to *(SITE NAME)*
Student's Name

to administer treatment to my child.

Furthermore, in case of an injury or illness that is life threatening or in need of emergency treatment, I authorize the *(SITE NAME)* staff to summon any and all professional emergency personnel to attend, transport, and treat the student and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnostic, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to participate in the state in which such treatment is to occur.

I authorize the *(SITE NAME)*staff to administer topical Benadryl ointment/cream to my child in case of redness, swelling, itching, and/or mild rash as a result of external allergens (e.g. cats, horses, dust, bug bites, detergent, soap, and any other allergens). I will provide Villa Lyan and/or Creative Children Therapy with a detailed list of any and all allergies of the student.

Student's Name _____

Mother's Name _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Mother/Legal Guardian _____ Date _____

Father's Name _____ Home Phone: _____

Address: _____ Cell Phone: _____

Signature of Father/Legal Guardian _____ Date _____

HEAD LICE

- A parasitic insect that can be found on the head, generally near the scalp and neck
- They move by crawling, not hopping or flying
- Lice are spread by:
  - Head-to-Head Contact
  - The Sharing Of:
    - Hats
    - Scarves
    - Coats
    - Combs/brushes
    - Towels

FIRST AID & CPR CERTIFICATION

American Heart Association® | American Stroke Association®
Learn and Live®

American Red Cross

redcross.org

ProCPR.org

online course

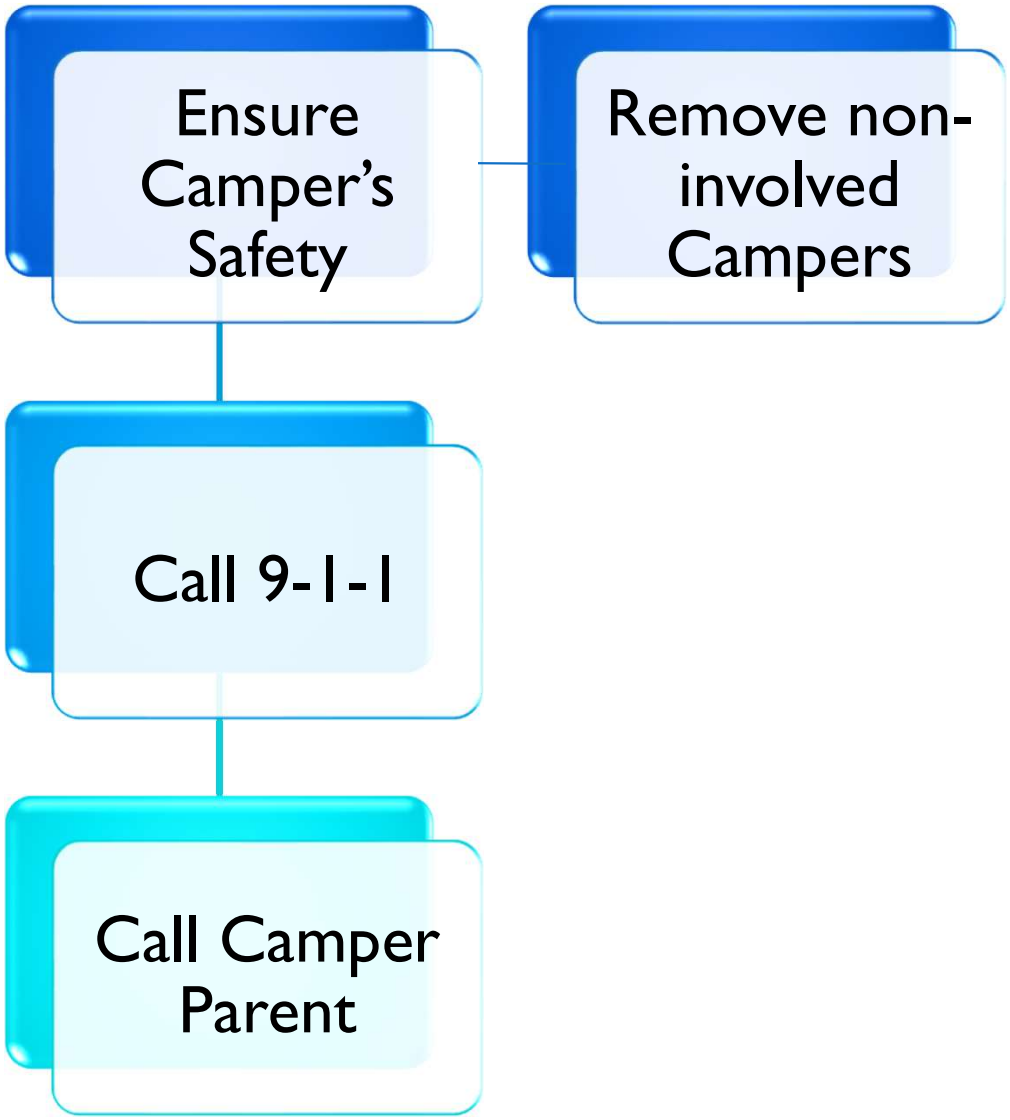
RESPONSE METHODS & SAFETY AWARENESS

- Familiarity with response methods
- Remain calm
- Risk Management
- Awareness of Environment
- Engage in Universal Precautions

ACTIVATING 911 SYSTEM

- What is your 911 system?
- Create an action plan delineating the steps to follow and the individuals to contact
- Emergency Phone list should include first and secondary individuals to be notified
- Time and effectiveness can lead to a better resolve and outcome of any situation

Hierarchy



List

1. Ensure Camper's Safety
2. Call 9-1-1
3. Remove non-involved campers
4. Call Camper Parent

INCIDENT REPORTS

- Need to complete AS SOON AS POSSIBLE
- Complete for any type of incident
- Need to include:
  - Name of employee reporting
  - Witness
  - Supervisor Signature
  - Provide a copy to parent/caregiver

Incident Report Form

Staff's Name Reporting Incident: _____ Date: _____

1. Who was involved in the incident?

_____

2. Please describe the incident:

_____

_____

_____

_____

_____

3. Did any injuries, illnesses occur as a result of incident? ____ YES ____ NO

If **YES**, please describe: _____

_____

Course of Action Taken: _____

_____

4. Location of incident: _____

5. When did the incident occur?
Date: ____/____/____ Time: _____ AM PM (Circle One)

6. Did anyone witness the incident? _____ YES _____NO

If YES, please list names/position: _____

_____

7. Did you report the incident? ____ YES ____NO

If **YES**, to whom did you report it to? *Parent* *Caregiver* (Circle One)

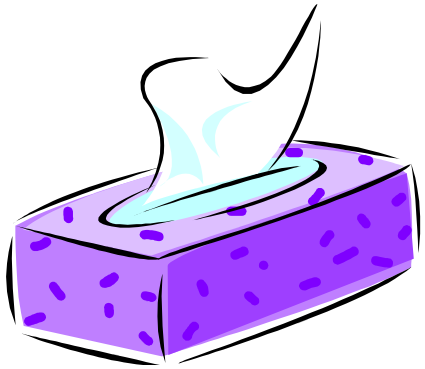
Other: _____

If **NO**, why did you not report it? _____

_____

Staff's Signature: _____ **Caregiver's Signature:**_____

Supervisor's Signature: _____



EMERGENCY BAG

INFORM STAFF

- Maintain staff:
  - Informed of all campers medical needs
  - Informed of any changes to campers medical needs or situation
  - With copies of all Emergency Action Plans signed by the parent to be kept in the Emergency Bag

ADMINISTERING MEDICINE

- Staff can not administer any medicine without consent from the parent/caregiver!!!
  - This includes TYLENOL
- Ask a local EMT/Paramedic from a local fire department to conduct an inservice for your staff on administration of medicines and basic protocols for emergencies and health concerns
- Parent should demonstrate how to use medication provided for camper

Authorization for Medication

I, _____ the parent and/or guardian of
Parent/Legal Guardian Name

_____, authorize the staff of *(SITE NAME)*
Student's Name

to administer the following designated medication to my child.

Name of Medication: _____

Describe the Circumstances under which the medication is to be administered:

_____

_____

Dosage: _____ Time: _____

In detail, describe how to administer the medication:

_____

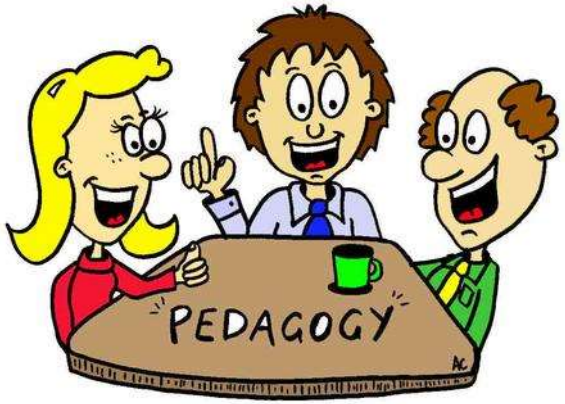
_____

Parent/Legal Guardian Name _____

Signature of Parent/Legal Guardian _____ Date _____

STAFF TRAINING

- Staff needs to receive proper orientation on all of the previously mentioned areas in order to be effective and well informed prior to the start of camp
- Proper training reduces misconceptions



Resources

- FARE – Food Allergy Research & Education www.foodallergy.com
- The Food Allergy and Anaphylaxis Network
- Emergency First Aid for Anaphylaxis – The Children's Trust website
- www.asthma.com
- www.epilepsy.com Epilepsy Foundation
- www.epipen.com
- www.jdrf.org

BE SAFE AND HAVE A FUN FILLED CAMP!