

Y Camp Allergy and Medical Emergency Care Plan 2020



Directions: Please complete this form if your camper has allergies or medical condition such that emergency care may be required. Please read sections in the Camp Parent Manual on allergies and health & wellness. It is the responsibility of the parent/guardian to provide all medications and medication order forms for any medications listed on this form.

Camper Information

Camper's Name		Date of Birth
Camper's Address		Phone
Grade - Fall 2020	Group Name (Buccaneer, Pioneer, Ranger, Explorers, Adventurer, Navigators, Specialty)	Camp Location(s)
Insurance policy/Doctor's name (if available, write N/A if no insurance)		Policy Number
		Emergency Number

Parent/Guardian Information

Name (Parent/Guardian)	Daytime Phone #1	Daytime Phone #2
Name (Parent/Guardian)	Daytime Phone #1	Daytime Phone #2

Allergy and Medical Information

Type of Allergy or Medical Condition: _____

Triggers of allergic reaction or medical condition: _____

Possible signs or symptoms: _____

Other considerations: _____

Medication(s) required to treat allergic reaction or medical condition: _____

Have these medications been provided to Y Camp: Yes No If No, I understand that medications are not provided and will not be readily available for my camper. Parent Signature _____

A Medication Administration Form with doctor's signature must be on file for each medication in order for Y Camp to administer it. All forms can be found at ymaryland.org

ACTION STEPS to provide assistance to camper experiencing an emergency:

- Stay Calm. Stay with camper.
- Alert other staff for assistance and to contact Emergency Medical Services (911) and/or parent.
- Give medication in following order* (All medications listed below must be provided to Y Camp and accompanied by a Medication Administration form signed by a physician):

PLEASE LIST IN THE ORDER THE MEDICATIONS SHOULD BE GIVEN	Name of Medication	How to give	Amount	When to give/repeat
1. Medication given 1st				
2. Medication given 2nd				
3. Medication given 3rd				

- Monitor Camper for
 - Swelling of tongue, eyes, or lips
 - Swelling/tightness in throat
 - Loss of consciousness and/or collapse
 - Become pale and floppy
 - Vomiting, stomach cramps, or diarrhea
 - Difficulty breathing or noisy breathing
 - Difficulty talking and/or hoarse voice
 - Tightness of chest
 - A wheeze or persistent cough
 - Blue discoloration of lips and fingernails
- Administer CPR if breathing stops. Continue until paramedics arrive.
- Document event using a Y incident report form.

Allergy and Medical Emergency Care Plan Permission

I give consent for Y of Central Maryland authorities to take appropriate action for the safety and welfare of my child. I give my consent for Y of Central Maryland authorities to communicate with the authorized health care provider when necessary.

Parent/Guardian Signature _____

Date _____

*It is the responsibility of the parent/guardian to provide any and all medications listed. If the parent/guardian is choosing not to provide medication, please state intention above.



Y CAMP MEDICATION FORM – PARENT’S AUTHORIZATION

Directions: Complete one form for each medication administered at camp. Return this parent’s authorization form with medication and Medication Authorization Form to camp on or before your camper’s first day.

CAMPER INFORMATION

Camper Name	Birth Date
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Y CAMP LOCATIONS (please select all that apply)

Arundel County	Baltimore City	Baltimore County	Carroll County	Harford County	Howard County
The Y in Pasadena 26 Magothy Beach Rd., Pasadena, MD	The Weinberg Y in Waverly 900 E. 33rd St., Baltimore, MD	The Orokawa Y in Towson 600 W. Chesapeake Ave., Towson, MD	The Hill Y in Westminster 1719 Sykesville Rd., Westminster, MD	The Ward Y in Abingdon 101 Walter Ward Blvd., Abingdon, MD	The Dancel Y in Ellicott City 4331 Montgomery Rd., Ellicott City, MD
The Y in Arnold 1209 Ritchie Hwy, Arnold, MD	The Y in Druid Hill 1609 Druid Hill Ave., Baltimore, MD	The Y in Parkville 8910 Waltham Woods Rd., Parkville, MD	Camp Hashawha 300 John Owings Rd., Westminster, MD	Highlands School 2904 Creswell Rd., Bel Air, MD	St. John’s PDS 9130 Frederick Rd., Ellicott City, MD
Camp Whippoorwill 520 Lake Shore Dr., Pasadena, MD		The Y in Catonsville 850 S. Rolling Rd., Catonsville, MD		Camp Spencer 3373 Peach Orchard Rd., Street, MD	Camp Ilchester 5042 Ilchester Rd., Ellicott City, MD

PACKAGING INFORMATION

For prescription medications only

Is medication in original container or box with intact pharmacy label?
Pharmacy label must include directions, dosage, child’s name and expiration date.

Yes No - cannot be accepted

For non-prescriptions only

Is medication in original packaging with directions and dosage?
Original packaging must include directions, dosage, and expiration date.

Yes No - cannot be accepted

PARENT/GUARDIAN SIGNATURE

I grant the Y in Central Maryland permission to administer the medications as outlined on the Maryland Department of Health’s Medication Authorization Form. I understand this form must accompany a completed Medication Authorization Form, complete with prescriber’s signature.

PARENT/GUARDIAN SIGNATURE

DATE

CAMP USE ONLY

CAMP USE ONLY: Check-In

- | | |
|--|---|
| 1. Verify above information - complete and correct | 2. Put medication and form in labeled, zipped bag |
| 3. Put zipped bag in Med Box | 4. Update Medical Alert Chart |

STAFF NAME

DATE

CAMP USE ONLY: Check-Out

Date of Last Dose Given	Medication has been:	Date: _____
	<input type="checkbox"/> Returned to Parent	Date: _____
	<input type="checkbox"/> Destroyed	Date: _____
	<input type="checkbox"/> Depositor Form Complete	Date: _____

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

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, 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. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION									
1. CHILD'S NAME (First Middle Last)			2. DATE OF BIRTH (mm/dd/yyyy)						
3. MEDICATION SHALL BE ADMINISTERED					3a. FROM (mm/dd/yyyy)		3b. TO (mm/dd/yyyy)		
during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.									
Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)			
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med		
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>									
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med		
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>									
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med		
Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Known side effects:</i>									
4. PRESCRIBER'S NAME/TITLE					This space may be used for the Prescriber's Address Stamp				
TELEPHONE FAX									
ADDRESS									
CITY			STATE						
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) <small>(original signature or signature stamp only)</small>					5b. DATE (mm/dd/yyyy)				

Section II. PARENT/GUARDIAN AUTHORIZATION											
I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 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											
6a. PARENT/GUARDIAN SIGNATURE					6b. DATE (mm/dd/yyyy)		6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION				
6d. HOME PHONE #					6e. CELL PHONE #		6f. WORK PHONE #				
Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)											
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."											
7a. PRESCRIBER'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>					7b. DATE		8a. PARENT/GUARDIAN'S SIGNATURE <small>FOR SELF-ADMINISTRATION/SELF-CARRY</small>			8b. DATE	