SPECIALIZED HEALTH CARE SERVICES NEEDED AT CAMP

Girl Scout Council of Nation's Capital – Day and Evening Camp

Please have your child's primary healthcare provider complete this form and fax it to
The address listed in the Cover Letter
Keep the original copy for your own records

Name: _____ Camp Name: _____
Date of Birth: _____ Session: _____
Age: _____ Program: _____

ALLERGY ACTION PLAN Allergy to: _____

SYMPTOMS **GIVE CHECKED MEDICATION**

- If a food allergen has 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

DOSAGE

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

Antihistamine: Give _____ (medication name), _____ (dose), _____ (route).

Other: Give _____ (medication name), _____ (dose), _____ (route).

☐ Camper has permission to carry her own Epi-Pen and has been instructed in proper use.

☐ I prefer counselors carry my daughter's Epi-Pen with the understanding it will be available to her at all times.

EMS will be always be called if epinephrine is given whether or not the camper manifests any symptoms of anaphylaxis.

ASTHMA ACTION PLAN Triggers: _____

Name of Medication and Strength: Type of Device:

_____ _____
_____ _____
_____ _____

Times(s) Medication is Given: Time Interval for Repeating Dose:

_____ _____
_____ _____

If camper is taking more than one medication, list sequence in which medications are to be taken:

_____
_____

Camper has permission to carry her inhaler with her and has been instructed in proper use. ☐ Yes ☐ No

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

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Phone: _____
Physician's Signature: _____ Date: _____
Physician's Phone: _____

GSCNC SUMMER DAY AND EVENING
CAMPER MEDICATION PERMISSION FORM

Camper Name: _____

Camp Name: _____Dates of Camp: _____

- **IMPORTANT:** A Physician and parent must sign this form if any ***over-the-counter medications (i.e.*** Dramamine, vitamins, Pamprin, etc) are listed. A parent signature is sufficient if there are ***NO over-the-counter medications listed.***
- By law all prescription medications must be brought to camp in their **original containers**, with the doctor's instructions. DO NOT pre-dispense, place in a daily pill holder, wrap in outer materials, or ask us to dispense by other than doctor's orders. Do not bring expired medications. Medications not in original containers will not be held or dispensed at camp.
- All prescription medicines must be in original container with **pharmacy label** with prescription number, date filled, prescribing physician's name, name of medication, directions for use, and the patients name. All Over-the-Counter medications must be in **original container** should have the campers name written on the box.
- At least one dose of any medication MUST be given to camper at home before bringing to camp.
- Indicate what time the medication is to be taken.
- Please indicate if medicine is taken daily or as needed
- You must be specific with any variations or conditions associated with "as needed"

Use additional form if more room is needed.

Medication Name	Reason taking	Date of dose taken at home prior to camp	**Dosage**	Breakfast	Lunch	Other: (specify what time)	As needed

Parent/guardian_____Date_____

Licensed Physician _____Date _____
(Necessary for ANY and ALL Over the Counter Medication)

Address_____

Phone_____Fax_____