Campers with Allergies/Asthma/Other Meds

The Woodcock Nature Center's Summer Camp program is a State of Connecticut licensed summer camp. This certification requires us to follow strict guidelines with regards to additional care needs at camp. Additional care needs are health or related care that is beyond what is generally required by children. These may include any medical, physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition (including allergies or asthma that require epipens, antihistamines, inhalers or other medications while attending camp).

If your child has additional care needs, every step listed below must be completed. **Your child will not be allowed to attend camp if we do not have all of the items listed below.**

Forms required:

- **Individual Plan of Care** form (to be filled out by Parent/Guardian).
- **Authorization for Administration of Medicine** form for each individual medication (to be filled out by the prescribing doctor and signed by the parent.)
    - **Allergy Emergency Plan** or **Allergy Emergency Protocol Form** (provided by the prescribing doctor) is also required for campers with epipen allergies. This is the step by step protocol for the administration of medications in an emergency.

Medications at Camp:

- All medications must have a prescription label. Medications without prescription labels will not be accepted. If you are missing a label, you can obtain one from your pharmacist.
- Expired medication will not be accepted.
- **Epipens**: WNC requires **two** Epipens at camp. The pens will be separated; One will stay in the office with the Director of First Aid and one will be carried by the camper's counselor at all times. Each pen will need its own prescription label (additional labels can be obtained from your pharmacist). Each Epipen needs to be placed in its own Ziploc bag with your child's name on it and the Allergy Emergency Plan.
- **Inhalers:** Each inhaler will need its own prescription label and be packed in a Ziplock bag with the child's name on it.
- **Other Prescription Medication:** All prescription medication must have a prescription label and be in the original container packed in a Ziplock bag with the child's name on it. Loose tablets or loose blister packs will not be accepted.
- **OTC Medications** (i.e. Benadryl, Zyrtec, Lactaid, etc.): All over the counter medications must be in their original packaging or will not be accepted (ie: doses in blister packs must be in original box).
- Medications will be received by Senior Staff at drop-off Monday morning and be checked for expiration dates and proper packaging. They will be returned to Parents at check out Friday each week unless otherwise arranged. WNC will keep medications securely stored through the camp week. If your child's last day of camp will be other than Friday, it is your responsibility to let us know in advance so we can arrange to return medications to you on the appropriate day at check out.

***IMPORTANT* In order for your child to be admitted to camp, required forms must be provided in advance, and all medication must be properly packaged and labeled as noted above and must not be expired.**

woodcock nature center

Individual Plan of Care

For a Child with Allergies, Special Health Care Needs or Disabilities

An Individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Child's Name: _____ Date of Birth: ____/_____/_____

Describe Special Health Care Need or Disability: _____

Outline the plan for the appropriate care of the child in a medical emergency.
(If a written plan from the doctor/allergist already exists, it can be attached to this form.)

_____

_____

_____

_____

Other relevant information (e.g. precautions to be taken to prevent a medical or other emergency): _____

_____

Signature of Parent/Guardian:

_____ Date Signed: ____/_____/_____

Signature of Staff responsible for the child (for WNC use):

Printed Name	Signature	Date Signed:
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____
_____	_____	____/_____/_____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history or contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

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Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)