Checklist with instructions-- 2018 NYLT Medical Packet

Submission deadline: May 1, 2018* Mail hard copies to the registrar for your session. Do not send to council office please.
Please complete all requested information in compliance with BSA and State of Colorado requirements.

This packet contains all the current, required forms. Please **do not substitute** any other forms. Please read the following information carefully. The health and safety of our youth is always our first priority. Incomplete or inaccurate information may place the youth and staff at risk at camp or in an emergency or delay appropriate treatment. It is required that forms be submitted early to ensure that the medical staff has time to review, evaluate and prepare for the medical needs of every Scout in advance.

Part A: Consent and release

☐ Read / fill in bullet / list restrictions for the "Informed consent, release, and authorization to provide medical care".
☐ **Parent and participant signatures please**.
☐ Complete -Adult authorized to transport youth. Someone must be listed even if it is yourself. Include phone numbers.
☐ Complete- Adults NOT authorized to transport youth- list name(s) or Mark N/A (Colorado requirement)

Part B: Medical history. **Fill every line and mark every box**.

☐ Provide **two** (2) emergency contacts with phone numbers that will be local and available during the week of camp.
***Colorado requires one NON-PARENT emergency contact**.
☐ Include a clear photo copy of BOTH sides of your **health insurance card**
☐ Complete health history with explanations for "yes" answers. Check all 4 allergy boxes yes or no. Please contact the registrar if your Scout has any food or other serious allergies or medical conditions that may require advance medical or food preparation.
☐ Fill in NO MEDS bullet if appropriate. Physician signature is required even with NO meds listed.
☐ Clearly list all medications, include full name, dosage, frequency and when to dispense, (ie: AM/PM, with/without food) Meds are normally dispensed just before or after breakfast and in the evening after dinner. *Please print clearly*. Safety is most important, unclear or unreadable information makes proper dispensing of meds difficult.
Two (2) Epi-Pens and Inhalers are required at camp.
☐ Choose yes or no for permission to administer non-prescription medications.
☐ **Physician signature/date is required on Part B with** or without medications listed.
*****NOTE**: Please submit an unsigned Part B by the deadline if your physician visit is delayed due to insurance restrictions. Submit a second copy of Part B with signature when sending Part C.
☐ Immunizations-- check appropriate box- complete dates- Tetanus must be current (less then 10 years)

Asthma or Allergy Anaphylaxis Action plan- If your scout lists an inhaler or Epi-pen- please complete the required appropriate form included in the packet. Colorado requires parent and physician signatures.

Part C: **Pre-Participation Physical**. Please plan ahead, schedule appointments early to complete this form on time. Please review the form and be sure the physician completes every area and check box.
☐ **A Physician must sign and date both Part C and Part B and the Action Plan**
*****NOTE:** The staff understands that insurance limitations may delay the completion of Part C, the physician examination- and signed Part B. Please contact the registrar before the deadline for approval of delayed submission of **signed Part B and Part C**
All remaining forms must be submitted by the deadline.

Colorado Addendum-Parent Authorization Form. Do not substitute any other form.
☐ Complete name, date of birth, and guardian information in top section**.**
☐ Fill in **ALL** immunization dates or attach a printed record of immunization to the top section- mark "see attached". Tetanus must be up to date (less that 10 years).
☐ If your scout is all or partially IMMUNIZATION EXEMPT for any reason please fill out the BSA "Immunization Exempt Request" form and it must be included with your Medical Form Packet.
http://www.denverboyscouts.org/openrosters/DocDownload.aspx?id=169328
Complete **ALL 4 sections** in the Parent Authorization lower portion completely (Colorado requirement)
☐ 1. Parent/ Guardian information- complete all information- both parents required.
☐ 2. Individual authorization for travel. Mark N/A if does not apply
☐ **3. Signature required** in authorization for above named person(scout) to participate in all trips and excursions away from the campsite.
☐ **4. Signature required.** List restrictions of activities or mark N/A

Over the Counter medication permission form- please bring this form to your doctor for review.
☐ Please mark "yes" OR "no" for each item listed. Indicated any allergy information.
☐ **Parent/Guardian Signature required**

Remember: we do not need originals, please send CLEAR copies. We recommend you keep copies for yourself of your medical packet for your future use. All medical forms provided to the NYLT program will not be returned.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/ Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

! **NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.** !

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Telephone: _____

Name: _____

Telephone: _____

Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

! **Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.** !

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

Part B: General Information/Health History

B

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:** _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐	☐	Tetanus	
☐	☐	☐	Pertussis	
☐	☐	☐	Diphtheria	
☐	☐	☐	Measles/mumps/rubella	
☐	☐	☐	Polio	
☐	☐	☐	Chicken Pox	
☐	☐	☐	Hepatitis A	
☐	☐	☐	Hepatitis B	
☐	☐	☐	Meningitis	
☐	☐	☐	Influenza	
☐	☐	☐	Other (i.e., HIB)	
☐	☐	☐	Exemption to immunizations (**form required**)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX
Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

! **You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.** !

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches):_____ **Weight (lbs.):**_____ **BMI:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/ throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Does not have uncontrolled heart disease, asthma, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
☐	☐	**For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.**

Examiner's Signature: _____ **Date:** _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions
If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH SCOUT ATTENDING A COLORADO SCOUT CAMP

Name_____ **Date of Birth**_____

Parent/Guardian_____ **Dates of the Camp Session**_____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT CERTIFICATE OF IMMUNIZATION

Vaccine		(Enter the month, day and year each immunization was given.)					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date_____		Lab Verification Date_____	

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM CAMP AND TO QUARANTINE.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

Signed _____ Date _____
Physician (Medico)

Medical exemption *to the following vaccine(s):*
La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Religious exemption *to the following vaccine(s):*
Exención por motives religiosos *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

Signed _____ Date _____
Parent, guardian, emancipated Scout/counseling minor

Personal exemption *to the following vaccine(s):*
Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ HepB ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PARENT/GUARDIAN AUTHORIZATIONS

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Telephone Day_____
Eve_____ Cell_____
Place of Employment_____
Address_____
Phone #_____

Individual authorized to take the Scout from camp if different from the parent or guardian:
Name_____ Address_____ City_____ ST____ Zip_____
Phone # Day_____ Eve_____ Cell_____

I hereby authorize the above named person to participate in all special trips or excursions in which the Scout may be walking or riding away from the campsite.
Parent/Guardian/Custodial Adult_____ Date_____

The above named person is restricted from the activities listed below:
_____ _____
_____ _____
_____ _____
_____ _____

Parent/Guardian/Custodial Adult_____ Date_____

Scout Name:_____ **Date of Birth:**_____

Allergic to:_____

Over-the Counter Medication Dispensation Permission Form

Purpose: The Medical Staff has limited supplies of the medications listed below, if you know your scout will possibly need one of these, please send it (preferably new) with them, in the original container and labeled with their name.

YOU ARE GIVING PERMISSION FOR THE FOLLOWING MEDICATIONS TO BE GIVEN IF INDICATED, IF NEEDED. MEDICATIONS WILL BE ADMINISTERED IN ACCORDANCE WITH THE DOSAGES ON THE OTC MEDICAL CONTAINER

YES	NO	Medication
◯	◯	Acetaminophen (Tylenol®)
◯	◯	Ibuprofen (Advil®/Motrin®)
◯	◯	Diphenhydramine (Benadryl®)
◯	◯	Loratadine (Claritin®)
◯	◯	Cetirizine HCL (Zyrtec®)
◯	◯	Cough Drops or Throat Lozenges
◯	◯	1% Hydrocortisone Cream
◯	◯	Antibiotic topical ointment (Bacitracin®)
◯	◯	Sunscreen Lotion
◯	◯	Sunburn Gel (Solarcaine®, Aloe Vera, Lip Balm)
◯	◯	Skin Itch Treatment (Calamine Lotion)
◯	◯	Calcium Carbonate (Tums®)
◯	◯	Magnesium Sulfate (Epsom Salts®)
◯	◯	Midol® (Females Only)

WAIVER: In consideration of the benefits to be derived, in view of the fact that participation in Scouting Activities is voluntary, and having full confidence that reasonable precautions will be taken to ensure my Scout's safety and well-being, I agree to their participation in Scouting Activities and waive all claims against the leaders of NYLT, BSA Scouting Activity, and/or its sponsor. I have provided the Denver Area Council with current and accurate medical information about my Scout.

Signature (Parent):_____ Date: _____

Print Name (Parent):_____

Emergency Contact Phone Number: _____

Copy Front and Back side of **Medical Insurance Card** onto this single sheet

This card is for (name): _____

FRONT OF CARD

BACK OF CARD

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.	
Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade: DAC BSA	Teacher: NYLT/BIG HORN

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: _____

☐ **Life threatening allergy** : Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____ _____ _____ ☐ 504 PLAN OR IEP

PARENT SIGNATURE | DATE | SCHOOL NURSE SIGNATURE | DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other:_____10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	**DO THIS:**
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other:_____ ☐ 2 puffs ☐ Other:_____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other:_____ ☐ 2 puffs ☐ Other:_____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other:_____ ☐ 2 puffs ☐ Other:_____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location)_____.

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE | PRINT PROVIDER'S NAME | PHONE/FAX | DATE

Copies of plan provided to: Teacher(s) ___ Phys Ed/Coach ___ Principal___ Main Office ___ Bus Driver ___ Other _____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____D.O.B. _____ Grade: DAC BSA
School: Camp Tahosa Teacher: NYLT/BIG HORN
ALLERGY TO: _____
HISTORY:_____
_____

Asthma: ◯ YES (higher risk for severe reaction) ◯ NO

Place child's photo here

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
LUNG: Short of breath, wheeze, 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, severe diarrhea
OTHER: Feeling something bad is about to happen, confusion

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 and activate school emergency response team
3. Call parent/guardian and school nurse
4. Monitor student; keep them lying down
5. Administer Inhaler (quick relief) if ordered
6. Be prepared to administer 2nd dose of epinephrine if needed

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
NOSE: Itchy, runny nose, sneezing
SKIN: A few hives, mild itch
GUT: Mild nausea/discomfort

→

1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. Follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____minutes or more, or symptoms return, 2nd dose of epinephrine should be given

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler: (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ◯ Yes ◯ No

Provider (print) _____Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____1) _____ 2) _____
   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____