REQUIRED MEDICAL FORMS

All troops/packs send in medical forms with their Scoutmaster a week prior, during the Pre-Camp Meeting. All Scouts and Scouters must have a completed medical form to spend the week in camp. a Scout's health history must be filled out and signed by the parent/guardian within the past year and the medication signature must be within 90 days. The Camp Health Officer will check and collect all forms not previously turned in, as well as medications during check-in.

PLEASE SUBMIT A PHOTOCOPIED HEALTH FORM

Scouts not meeting the medical examination requirements will not be permitted to remain in camp. This pertains to all participating Scouts and leaders, no matter how long their stay in camp may be, ***including temporary leadership****.*

EACH MEDICATION TO BE ADMINISTERED BY THE HEALTH OFFICER WILL NEED:

- "Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel" - page 24
- The doctor needs to fill out a form for each medication to be administered, including any over-the-counter, vitamins, inhalers, and EpiPens
- If the "Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel" is not complete - the medication cannot be administered at Camp.

NO MEDICAL EXAMINATIONS CAN BE GIVEN AT CAMP!

MEDICATIONS

All medications for Scouts and Scouters must be turned into the Health Officer during check-in. The Health Officer will be located at the medical check-in station at the Health Lodge. All medications must have a ***photo of the camper*** *attached. Each form of medication must have a date as well as a doctor's name on the container.*

Medications must be in the original container with an attached photo!
Please bring only the amount of medication necessary for the week

<u>MEDICAL FORMS CHECKLIST FOR EACH CAMPER:</u>

□ Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel (If over 18, not required)
□ Scouting America Annual Medical Form
□ Medical Addendum
□ Non-prescription medication must also be left at the Health Lodge. This is a state law.

Phone: 203.734.3329

https://www.housatonicscouting.org

Housatonic Council, Scouting America Office
111 New Haven Avenue, Derby, CT 06418

The Edmund D. Strang Scout Reservation
278 Westside Road, Goshen, CT 06756

MEDICAL ADDENDUM SIGNATURE

(must be completed by parent / guardian for scouts under 18 years old)

Scout's Name: _____ Troop #: _____ Week(s): _____

This addendum to the annual scouting health and medical record is for Scouts under 18 years of age and is required to meet Connecticut Department of Health requirements.

I give my permission for the camp health officer/nurse to administer over the counter medications as directed by the camp position in the camp standing orders. the Housatonic council's policies on medications at Scout camp are written to comply with the national standards of the Boy Scouts of America and the state of Connecticut Health department.

If you do not wish to have any of the following over the counter medications administered, please cross out and initial.

Over-the-Counter Medications may include:

(Generics may be substituted)

- Tylenol by mouth, per weight / age dosing as needed every 4 to 6 hours
- Advil by mouth, per weight / age dosing as needed every 6 to 8 hours
- Bacitracin / Neosporin / Hydrogen Peroxide topically as needed
- Hydrocortisone Cream topically every 6 hours as needed
- Benadryl by mouth, per weight / age dosing as needed, per package directions
- Claritin by mouth, per package directions
- Sudafed by mouth, per package directions
- Zantac by mouth, per package directions
- Sunscreen topically, as needed
- Bug repellent topically, as needed every 2 to 4 hours
- Solarcaine / Aloe Vera topically as needed every 2 to 4 hours

Signature: _____ Date: _____

*****Reminder - Prescription medications must be in the original pharmacy container with label, this includes EPI-Pens. Please bring only amount needed for a camp. Failure to comply will result in the inability for the medications to be ministered at camp. Any medication not picked up within one week after scout leaves Camp will be destroyed.***

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

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day 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 to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State____

E-mail: _____ Cell Phone # (_____) _____-_____ Other Phone # (_____) _____-_____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication specified on this form: _____ YES _____NO
2. Student to possess medication specified on this form: _____ YES _____NO

Prescriber's Authorization and Signature: _____ Date:_____

Parent/Guardian Authorization and Signature: _____ Date: _____

School nurse (RN) Approval of self-administration (if applicable): _____ Date: _____

Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position/ _____ Date: _____

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INDIVIDUAL PLAN OF CARE

With Special Health Care Needs or Disabilities

Camper Name: _____ Unit # _____ Camp Week# _____

Date of Plan: _____

Special health care need(s) or disability: _____

Plan for appropriate care of the child in a medical emergency. 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 orprovided while the child is at the youth camp.

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

Parent(s)
/Guardian(s) Signature: _____ Date: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

signature(s) of all staff responsible for the care of this child.

Scouting America

Housatonic Council

INDIVIDUAL PLAN OF CARE

Signature of the staff responsible for_____

(name of child)

Printed Name	Signature	Date Signed

**Check medication administration form*

NOTE: Section 428-J(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 of 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. Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.

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Camper Name: _____ Unit # _____ Camp Week# _____

Diagnosis: Asthma **Date of Plan: _____**

Plan of Care:

Camper to notify RN of symptoms and camper's counselor to be on the lookout for the following symptoms:

- increased shortness of breath at rest or with activity
- wheezing
- chest tightness
- cough
- Other: _____

What is the camper's asthma triggers?

*Check all that apply

- ❑ Pollen
- ❑ Dust
- ❑ Exercise
- ❑ Animals
  - Type: _____

- ❑ Seasonal/Temperature Changes
- ❑ Cold/Virus
- ❑ Smoke
- ❑ Other: _____

Did the camper bring an inhaler to camp? (circle)

YES or NO

If yes, is the camper allowed to self-administer the medication? (circle)

YES or NO

Name of Camper: _____

Camper to report the infirmary to see RN for inhaler when needed or counselor to alert the RN if

Check medication administration form

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the inhaler needs to be brought to a specific location.

- RN to administer PRN inhaler, if order is in place.
- Camper to rest in the infirmary until RN feels camper can return to group/activity.

  Camper to report to the infirmary prior to physical activity to receive inhaler. (circle)

  YES or NO

Notify parent/guardian:

- If camper is requiring inhaler more than three days in a week to control asthma symptoms not due to normal activity.

- Other: _____

Signature of the staff responsible for_____

(name of child)

MD Name: _____ MD Phone #: _____

Parent(s)
/Guardian(s) Signature: _____ Date: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Check medication administration form

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INDIVIDUAL PLAN OF CARE

Signature of the staff responsible for_____

(name of child)

Printed Name	Signature	Date Signed

**Check medication administration form*

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INDIVIDUAL PLAN OF CARE

Camper Name: _____ Unit # _____ Camp Week# _____

Diagnosis: Diabetes **Date of Plan: _____**

Plan of Care:

Check which type

- ❑ Type 1
- ❑ Type 2

Blood Glucose Monitoring:

Target range for blood glucose: _____ mg/dL to _____ mg/dL

Type of blood glucose meter camper uses: _____

Usual times to check blood glucose: _____

Times to do additional checks:

*Check all that apply

- ❑ Before exercise
- ❑ After exercise
- ❑ When camper exhibits symptoms of hyperglycemia
- ❑ When camper exhibits symptoms of hypoglycemia
- ❑ Other (explain): _____

Does the camper take insulin? (Circle) YES or NO

Time	Type	Dosage

Can camper give own injections? (Circle response) YES or NO

**Check medication administration form*

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INDIVIDUAL PLAN OF CARE

Name of Camper: _____

Does camper have an insulin pump? (Circle response) YES or NO

Type of pump: _____

Insulin/carbohydrate ratio: _____ / _____

Correction factor: _____

Does the camper know how to use the pump (competent)? (Circle response) YES or NO

Does the camper know how to troubleshoot problems (e.g., pump malfunctions)? (Circle response) YES or NO

Comments: _____

_____

Does the camper count carbohydrates to be eaten/eaten at meals and snacks? (Circle response) YES or NO

	Food Content / Amount:
Breakfast	
A.M. Snack	
Lunch	
P.M. Snack	
Dinner	

Snack before exercise? (Circle Response) YES or NO

If yes, explain: _____

Snack after exercise? (Circle Response) YES or NO

If yes, explain: _____

Other times to provide camper with a snack - content/amount: _____

Name of Camper: _____

**Check medication administration form*

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Housatonic Council

INDIVIDUAL PLAN OF CARE

Signs of Hypoglycemia (low blood sugar):

❑ Sweating	❑ Anxiety
❑ Irritability	❑ Confusion
❑ Lack of coordination	❑ Blurred / Double Vision
❑ Sleepiness	❑ Cool Clammy Skin
❑ Hunger	❑ Other: _____
❑ Palor (Pale)	_____

If camper is exhibiting any of the above symptoms:

- ❑ Camper's counselor will notify RN
- ❑ RN will check camper's blood sugar.
  - If camper's blood sugar is less than camper's target number of _____ mg/dL
    - RN will administer snack
    - Other treatment: _____
    - RN to re-check camper's blood glucose level in hourly until level returns to within camper's targeted range

Signs of Hyperglycemia (high blood sugar):

❑ Dry Mouth	❑ Frequent Urination
❑ Weakness	❑ Difficulty Concentration
❑ Blurred Vision	❑ Dry Skin
❑ Increased Thirst	❑ Nausea
❑ Headache	

If camper exhibiting any of the above symptoms:

- ❑ Counselor to notify the RN.
- ❑ RN to check camper's blood glucose level.
  - If camper's blood sugar is greater than camper's target number of _____ mg/dL
    - RN to administer supplemental insulin if order in place
    - RN to provide camper water/non sugary drinks
    - RN to assess camper's blood sugar level hourly until level returns to within camper's targeted range.

Name of Camper: _____

**Check medication administration form*

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Housatonic Council

INDIVIDUAL PLAN OF CARE

Call 911 if camper:

- ❑ Loses consciousness and/or is unresponsive
    - ○ RN to monitor breathing, pulse, circulation
- ❑ Has a seizure(convulsion)
- ❑ Unable to swallow - if camper is hypoglycemic
- ❑ RN feels camper needs a higher level of care

Notify Camp Director of event.

Notify camper's parent(s)/guardian(s).

Parents agree to maintain equipment and supplies

Example: BS machine - _____

MD Name: _____ MD Phone #: _____

Parent(s)
/Guardian(s) Signature: _____ Date: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Signature of the staff responsible for_____

**Check medication administration form*

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Housatonic Council

INDIVIDUAL PLAN OF CARE

Signature of the staff responsible for_____

(name of child)

Printed Name	Signature	Date Signed

**Check medication administration form*

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INDIVIDUAL PLAN OF CARE

Camper Name: _____ Unit # _____ Camp Week# _____

Diagnosis: Seizures **Date of Plan: _____**

Plan of Care:

Camper has a history of: (Check all that apply)

- ❑ Tonic (Muscle stiffness, rigidity)
- ❑ Grand Mal (unconsciousness, muscle rigidity, convulsions)
- ❑ Absence (brief sudden lapse of consciousness, "daydreaming", return to normal alertness
- ❑ Myoclonic (sporadic[isolated], jerking movements)
- ❑ Atonic (loss of muscle tone)
- ❑ Clonic (repetative jerking movements)

Last known seizure: _____

If camper has a seizure, counselor(s) to:

- ❑ Stay calm and alert RN
- ❑ Track time/length of seizure
- ❑ Clear everything in the area around the camper
- ❑ Do NOT put anything in the camper's mouth
- ❑ Stay with the camper until fully conscious or until the RN arrives

RN to administer PRN medication (if camper has any ordered).

Does the camper have any PRN medication ordered while at camp? (Check response)

- ❑ YES

  If yes, what medication? _____

- ❑ No

Name of Camper:_____

**Check medication administration form*

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Housatonic Council

INDIVIDUAL PLAN OF CARE

Call 911 if:

- Convulsive seizure lasts > 3 minutes.
- Camper has repeated seizures without regaining consciousness
- Camper is injured of has diabetes
- Camper has difficulty breathing
- Camper has a seizure in the water

Notify parent(s)/guardian(s) or emergency contact.

Notify Camp Director of event.

MD Name: _____ MD Phone #: _____

Parent(s)
/Guardian(s) Signature: _____ Date: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s)
/Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

**Check medication administration form*

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Scouting America

Housatonic Council

INDIVIDUAL PLAN OF CARE

Signature of the staff responsible for_____

(name of child)

Printed Name	Signature	Date Signed

**Check medication administration form*

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Scouting America

Housatonic Council

INDIVIDUAL PLAN OF CARE

Camper Name: _____ Unit # _____ Camp Week# _____

Diagnosis: Risk of Anaphylactic **Date of Plan: _____**

Reaction Plan of Care:

If risk is related to food:

Food(s)? _____

- ❑ Kitchen staff to be notified of allergies and will check labels on all food being distributed.
- ❑ Camper's counselor(s) will need to monitor that the camper is choosing safe food options.
- ❑ NO sharing of food at camp. - Campers or counselors.
- ❑ RN to be notified if camper has ingested or has been suspected to have ingested their allergen.

If risk is NOT a food related allergy:

Allergen(s): _____

- If camper thinks they were in contact with their allergen, camper's counselor to notify RN immediately.

For ALL Allergic Reactions:

- RN to assess for signs and symptoms of an allergic reaction:

❑ Hives	❑ Hoarseness
❑ Wheezing	❑ Stomach Cramps/ Diarrhea
❑ Itchy mouth/throat	❑ Vomiting
❑ Chest Tightness	❑ Dizziness
❑ Cough	❑ Fainting
❑ Shortness of Breath	❑ Other: _____
❑ Swelling of lips/tongue/face/eyes	_____

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Housatonic Council

Name of Camper: _____

Administer PRN lifesaving medication in the following order (if applicable):

**Indicate the order in which to be administered by listing 1st, 2nd, etc.*

_____ Epi-Pen

- ❑ If the Epi-pen is administered, call 911.
  - o Camper to be transported via ambulance to the hospital for further monitoring and evaluation.
- ❑ RN to continue to assess camper and determine if 2nd Epi-pen (if camper has one) is to be administered.

_____ Benadryl

Does the camper have asthma? (circle) Yes or No

Notify Camp Director of event.

Notify the camper's parent(s)/guardian(s).

MD Name: _____ MD Phone #: _____

Parent(s) /Guardian(s) Signature: _____ Date: _____

Parent(s) /Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s) /Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Parent(s) /Guardian(s) Name: _____ Parent(s)/Guardian(s) Phone #: _____

Signature of the staff responsible for_____

(name of child)

**Check medication administration form*

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Housatonic Council

INDIVIDUAL PLAN OF CARE

Signature of the staff responsible for_____

(name of child)

Printed Name	Signature	Date Signed

**Check medication administration form*

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Scouting America

Housatonic Council

Attention Scout Parents:

For your son or daughter to carry his/her personal emergency medication (e.g. EPI pen, rescue inhaler, Insulin, etc.) while at camp the State of Connecticut Department of Public Health requires the statement below to be signed by the individual's medical provider and attached to the camper's physical form that is retained in the camp's health lodge.

Christopher L. Kellogg
Camp Director

****

Authorization to Carry Emergency Rescue Medication

_____ (check appropriate bow below)
Name of Camper - please print

Has demonstrated proper knowledge and ability to carry and self administer emergency medication specific to EPI pens, rescue inhalers and Insulin, etc.

Has demonstrated proper knowledge and ability to carry, but not self administer emergency medication specific to EPI pens, rescue inhalers and Insulin, etc.

Please indicate medication authorized (must also be listed on health form, Part B2, medications section):

EPI pen

Rescue Inhaler

Insulin

Other (specify) _____

Signature of health care provider: _____

Name of health care provider (printed): _____

Date: _____