# Camp Chatterbox Health Form

**FORM DATE:** _____ **DATE OF BIRTH:** _____

**ATTENDEE NAME:** _____

**ADDRESS:** _____

**EMERGENCY CONTACT & PHONE:** _____

**EMERGENCY CONTACT 2 & PHONE:** _____

**PHYSICIAN:** _____ **PHONE:** _____

**DENTIST:** _____ **PHONE:** _____

**INSURANCE COMPANY**: _____ **POLICY NUMBER**: _____

**HISTORY OF: SEIZURES?** YES / NO **ALLERGIES?** YES / NO **ASTHMA?** YES / NO
(Please complete an additional action plan form if attendee has seizures/asthma/allergies.)

**ATTENDEE'S IMMUNIZATIONS UP TO DATE:** YES / NO
(Please attach a copy of immunization record.)

**ATTENDEE WILL BE TAKING MEDICATION AT CAMP:** YES / NO
(Please note that all medications MUST be given to nurse at check in)

Please explain any known restrictions for activities, dietary restrictions, other precautions, health, or medical issues that our staff should be aware of: _____
_____
_____

**PARENT/GUARDIAN ASSISTANCE: (Parent/Guardian(s) and independent campers excluded):**
I acknowledge that I will accompany my child in activities in the event that the camp staff/volunteers are unable to attend the scheduled event.

_____
SIGNATURE OF PARENT/GUARDIAN DATE

**IN CASE OF EMERGENCY:** I certify that the above information is accurate & that this camper does not have any health or medical issues that would prohibit him/her from participating in this camp program. Permission is given to Children's Specialized Hospital or its representatives to provide or seek medical care in case of emergency for the above person.

_____
SIGNATURE OF ATTENDEE DATE

_____
SIGNATURE OF PARENT/GUARDIAN (if applicable*) DATE

_____
SIGNATURE OF PHYSICIAN DATE

_____
NAME OF PHYSICIAN AND PRACTICE – STAMP

Revised 10/20

*Parent/Guardian signature required for attendees under 18 and for those 18+ with a power of attorney

# Camp Chatterbox
# Seizure Action Plan

**FORM DATE:** _____ **DATE OF BIRTH:** _____

**ATTENDEE NAME:** _____ **TREATING PHYSICIAN:** _____

**SEIZURE INFORMATION**

| TYPE | LENGTH | FREQUENCY | DESCRIPTION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Triggers/Warning signs: _____

Response after a seizure: _____

**EMERGENCY RESPONSE**

A "seizure emergency" for this attendee is described as:

_____

_____

_____

**SEIZURE EMERGENCY PROTOCOL** (check all that apply & clarify below)

☐ Call 911 for transport to _____

☐ Notify parent or emergency contact

☐ Administer emergency medications as indicated below

☐ Notify doctor

☐ Other _____

**TREATMENT PROTOCOL DURING RECREATION PROGRAMS**

| EMERGENCY MEDS Y/N? | MEDICATION | DOSAGE & TIME OF DAY GIVEN | COMMON SIDE EFFECT / SPECIAL INSTRUCTIONS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

_____

SIGNATURE OF ATTENDEE DATE

_____

SIGNATURE OF PARENT/GUARDIAN (If applicable*) DATE

_____

SIGNATURE OF PHYSICIAN DATE

_____

NAME OF PHYSICIAN AND PRACTICE (STAMP)

Revised 10/20

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# Camp Chatterbox
# Allergy Action Plan

**FORM DATE:** _____ **DATE OF BIRTH:** _____

**ATTENDEE NAME:** _____

**ALLERGY TO:** _____

| SYMPTOMS | GIVE CHECKED MEDICATION |
|---|---|
| If an exposure to the allergens has occurred, but there are no symptoms | ☐ Antihistamine ☐ Epinephrine |
| **Mouth:** itching, tingling, swelling of lips, tongue, mouth | ☐ Antihistamine ☐ Epinephrine |
| **Skin:** hives, itchy rash, swelling of face or extremities | ☐ Antihistamine ☐ Epinephrine |
| **Gut:** nausea, abdominal cramping, vomiting, diarrhea | ☐ Antihistamine ☐ Epinephrine |
| **Throat:** tightening, hoarseness, hacking cough | ☐ Antihistamine ☐ Epinephrine |
| **Lung:** shortness of breath, repetitive cough, wheezing | ☐ Antihistamine ☐ Epinephrine |
| **Heart:** weak or thread pulse, low blood pressure, fainting, pale, blueness | ☐ Antihistamine ☐ Epinephrine |
| **Other symptoms:** | ☐ Antihistamine ☐ Epinephrine |
| If reaction is progressing, several of the above areas affected: | ☐ Antihistamine ☐ Epinephrine |

**DOSAGE**

Epinephrine (inject intramuscularly)

☐ EpiPen ☐ EpiPen Jr. ☐ Twinject 0.3 mg ☐ Twinject 0.15mg

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

**If a reaction occurs, emergency medication will be administered by camp nurse, 911 will be called prior to calling emergency contacts. An attendee's physician may also be contacted.**

_____
SIGNATURE OF ATTENDEE DATE

_____
SIGNATURE OF PARENT/GUARDIAN (If applicable*) DATE

_____
SIGNATURE OF PHYSICIAN DATE

_____
NAME OF PHYSICIAN AND PRACTICE – STAMP

Revised 10/20

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# Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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NJ Health New Jersey Department of Health

**(Please Print)**

| Name | Date of Birth | Effective Date |
|---|---|---|
| Doctor<br>Phone | Parent/Guardian (if applicable)<br>Phone | Emergency Contact<br>Phone |

## HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

**Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.**

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230 | 2 puffs twice a day |
| ☐ Aerospan™ | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Alvesco® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Dulera® ☐ 100, ☐ 200 | 2 puffs twice a day |
| ☐ Flovent® ☐ 44, ☐ 110, ☐ 220 | 2 puffs twice a day |
| ☐ Qvar® ☐ 40, ☐ 80 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Symbicort® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500 | 1 inhalation twice a day |
| ☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250 | 1 inhalation twice a day |
| ☐ Pulmicort Flexhaler® ☐ 90, ☐ 180 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0 | 1 unit nebulized ☐ once or ☐ twice a day |
| ☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg | 1 tablet daily |
| ☐ Other | |
| ☐ None | |

*Remember to rinse your mouth after taking inhaled medicine.*

**If exercise triggers your asthma, take _____ ____ puff(s) ____minutes before exercise.**

## CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 2 puffs every 4 hours as needed |
| ☐ Xopenex® | 2 puffs every 4 hours as needed |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Duoneb® | 1 unit nebulized every 4 hours as needed |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ Increase the dose of, or add: | |
| ☐ Other | |

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

## EMERGENCY (Red Zone)

**Your asthma is getting worse fast:**
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

**Take these medicines NOW and CALL 911.**
***Asthma can be a life-threatening illness. Do not wait!***

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 4 puffs every 20 minutes |
| ☐ Xopenex® | 4 puffs every 20 minutes |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 20 minutes |
| ☐ Duoneb® | 1 unit nebulized every 20 minutes |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 20 minutes |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ Other | |

## Triggers

**Check all items that trigger patient's asthma:**

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ❑ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ❑ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ❑ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.



**REVISED AUGUST 2014**
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**Permission to Self-administer Medication:**

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE_____
Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

**Make a copy for parent and for physician file, send original to school nurse or child care provider.**

Revised 10/20

# Asthma Treatment Plan – Student
## Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number

2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check "**OTHER**" **and:**
     - ❖ **Write in asthma medications not listed on the form**
     - ❖ **Write in additional medications that will control your asthma**
     - ❖ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

### PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

**FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.**

***RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY***

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

**The Pediatric/Adult Asthma Coalition of New Jersey**
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org



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Revised 10/20

# Medication Form

**Attendee Name**: _____ **D.O.B:** _____

**Diagnosis**: _____

**History of:** **Allergies** ____ Yes ____ No **Seizures** ____ Yes ____ No **Asthma** ____ Yes ____ No

*(Please complete additional emergency action plan if your child has history of any of the above conditions.)*

**Medications:** Please send along appropriate quantity of supplies for the full duration of camp. All medications must be given to and signed in with the camp nurse upon check-in for safe and proper storage; NO medications are permitted to remain in cabins.

If your camper may request additional "over the counter" medications (such as Tylenol, Motrin, Senokot, Immodium, antacid, Pepto Bismol, Benadryl, etc.) please provide a description in the chart below under "taken for" with the acceptable circumstances for administration of these medications. *Please do not just write "as needed".*

***Please note-over the counter medications must be new/sealed with a signed prescription provided by the child's primary physician. Medications without a doctor's authorization will not be administered under any circumstance.***

**Medication List:** *Please include routine, all over the counter and all emergency medications.*

| Medication Name | Dosage & Frequency | Taken for | Refrigeration Needed? | | Sign In/Sign Out (Nurse use only) | |
|---|---|---|---|---|---|---|
| | | | Yes | No | | |
| | | | Yes | No | | |
| | | | Yes | No | | |
| | | | Yes | No | | |
| | | | Yes | No | | |
| | | | Yes | No | | |
| | | | Yes | No | | |

**Notes**: _____

_____

_____

**Attendee Signature:** _____ **Date:** _____

**Parent Signature (If applicable):** _____ **Date:** _____

**Physician Signature & Stamp:** _____ **Date:** _____

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# Camp Chatterbox Independent Camper Feeding Form

Please provide adequate amount of supplies for the week as well as **tube extensions, plastic mixing pitcher labeled with the camper's name, and any other personal items you or your child may need during the week.** Please provide written 'recipe' below for formula preparation and delivery. Additionally, if the camper eats by mouth but requires supplemental GT feeds, please write the amount to be given, rate to be run, flush information, times to be administered, any free water, etc.

**Camper Name:** _____ **DOB:** _____

**Diagnosis:** _____

**If the camper is under the age of 18, is refusal of a feed permissible by camper? (Circle):** Yes / No

**Feeding Delivery (Check all that apply):** Continuous ____ Bolus ____ Overnight ____

**Daytime Formula Recipe**:

_____

_____

_____

| Times to administer | Amount per feeding | Over how many hours? | Rate to administer (per hr) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Water Flush Required? (Circle):** Yes / No **If Yes:** Amount _____ Rate _____

**Free Water? (Circle):** Yes / No **If Yes:** Amount _____ Rate _____

**Site Dressing? (Circle):** Yes / No **If Yes,** Type of Dressing: _____

**Overnight Formula Recipe**:

_____

_____

_____

| Times to administer | Amount per feeding | Over how many hours? | Rate to administer (per hr) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Water Flush Required? (Circle):** Yes / No **If Yes:** Amount _____ Rate _____

**Free Water? (Circle):** Yes / No **If Yes:** Amount _____ Rate _____

**Site Dressing? (Circle):** Yes / No **If Yes,** Type of Dressing: _____

**Additional Notes**:

_____

_____

_____

SIGNATURE OF CAMPER DATE

_____

SIGNATURE OF PARENT/GUARDIAN (If applicable) DATE

_____

SIGNATURE OF PHYSICIAN DATE

_____

NAME OF PHYSICIAN AND PRACTICE – STAMP

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