



# CAMPER HEALTH CERTIFICATE

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Participant Name: \_\_\_\_\_

Camp Year: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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Examining Care Provider \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

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## MEDICAL STATEMENT OF HEALTH

*I have examined \_\_\_\_\_ and find him/her to be in satisfactory physical condition, free from contagious disease, and capable of active participation in the regular camping program, only excepted as stated below.*

Doctor/CNP Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Exceptions: \_\_\_\_\_

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THIS FORM MUST BE COMPLETED AND UPLOADED IN YOUR TPBC ONLINE ACCOUNT NO LATER THAN TWO WEEKS BEFORE THE SCHEDULED START OF YOUR CHILD'S CAMP.

TWIN PEAKS BIBLE CAMP – 970.523.9077 – PO Box 907, Grand Junction, CO 81502 – Updated 2/2024

**NOTE: The Camper Medications Form is only required if your camper has medications or supplements not listed on our Standing Orders Medication List**



# CAMPER MEDICATIONS FORM

Participant Name \_\_\_\_\_

Camp Year \_\_\_\_\_ Participant Date of Birth \_\_\_\_\_

## Health Care Provider Information

Signing Care Provider \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

## HEALTH CARE PROVIDER MEDICATION AUTHORIZATION (Provider to Complete)

I authorize \_\_\_\_\_ to take the following medications at camp:

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**EMERGENCY MEDICATION ONLY:**  [I do] /  [I do NOT] authorize this child to self-carry and self-administer his/her EpiPen and/or inhaler. Care Provider Initials: \_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*Please use TPBC's "Camper Medications (Continued)" Page for additional medications.*

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# CAMPER MEDICATIONS FORM (CONT.)

## HEALTH CARE PROVIDER MEDICATION AUTHORIZATION (Provider to Complete)

I authorize \_\_\_\_\_ to take the following medications at camp:

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**Medication:** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Given at the following time/s: \_\_\_\_\_ Route: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

THIS FORM MUST BE COMPLETED AND UPLOADED IN YOUR TPBC ONLINE ACCOUNT NO LATER THAN TWO WEEKS BEFORE THE SCHEDULED START OF YOUR CHILD'S CAMP.

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# Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_



**ALLERGY TO:** \_\_\_\_\_

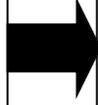
**HISTORY:** \_\_\_\_\_

**Asthma:**  YES (higher risk for severe reaction) – refer to their asthma care plan  
 NO

### ◇ STEP 1: TREATMENT ◇

**SEVERE SYMPTOMS:** Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms)
- OTHER: Feeling something bad is about to happen, Confusion, agitation



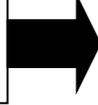
**1. INJECT EPINEPHRINE IMMEDIATELY**

2. Call 911
  - Ask for ambulance with epinephrine
  - Tell EMS when epinephrine was given
3. Stay with child and
  - Call parent/guardian and school nurse
  - Give second dose of epinephrine, if symptoms get worse, continue, or do not get better as instructed below
  - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinephrine. **USE EPINEPHRINE**

**MILD SYMPTOMS ONLY:**

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



1. Stay with child and
  - Alert parent and school nurse
  - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and 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, 2<sup>nd</sup> dose of epinephrine should be given if 2<sup>nd</sup> dose available

**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: \_\_\_\_\_

### ◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, **call 911**. State that an anaphylactic 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) \_\_\_\_\_

#### 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 and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_

Date: \_\_\_\_\_

To be completed by healthcare provider

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Staff trained and delegated to administer emergency medications in this plan:**

1. \_\_\_\_\_ Room \_\_\_\_\_

2. \_\_\_\_\_ Room \_\_\_\_\_

3. \_\_\_\_\_ Room \_\_\_\_\_

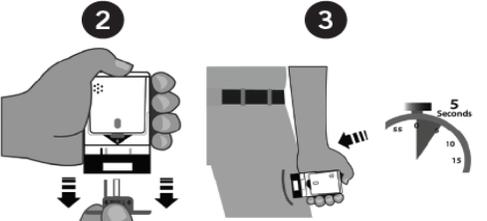
Self-carry contract on file:  Yes  No

Expiration date of epinephrine auto injector: \_\_\_\_\_

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

**AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS**

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



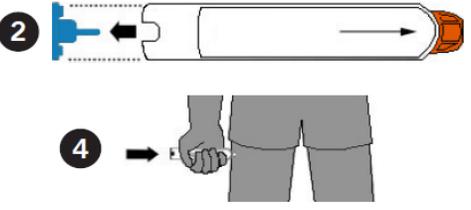
**ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



**EPIPEN® AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this condition warrants meal accommodations from food service, please complete the form for dietary disability if required by district policy.

Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017