

Place Camper's  
Picture Here



## Epi-Pen Prevention Plan

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Counselor's Name: \_\_\_\_\_

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

Asthmatic? Y/N) \_\_\_\_\_ (Yes=Higher Risk for Severe Reaction)

### Camp will:

- Have a Certified Medication Technician on site with on-call Delegating RN
- Have staff trained in CPR & First Aid
- Have staff trained in Allergy & Anaphylaxis
  - administering EpiPen® including demonstration & practice
- Emergency List distributed to: \_\_\_\_\_
- Have staff trained on individual emergency plans
- Camp staff will make every reasonable effort to prevent a camper's exposure to known allergens
- Other \_\_\_\_\_

### Parents will:

- Provide pertinent health information to the camp
- Provide Physician Authorization Forms and Action Plans
  - for camper medication and specific actions plans for emergency

### care

- Current, non-expired medications
- Provide safe snack option to camp/classroom
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

### Camper will:

- Make every effort to avoid contact with allergen
- Alert nearest adult if suspect exposure to allergen
- Other

### Notes:




# Management of Severe Allergic Reactions & Anaphylaxis



Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Counselor \_\_\_\_\_ Program: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 ALLERGYTO: \_\_\_\_\_  
 Asthmatic? (Y/N) \_\_\_\_\_ (Yes=Higher Risk for Severe Reaction)

## STEP1:TREATMENT

Symptoms	Give This Medication	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but <i>no symptoms</i> _____		
Mouth: itching, tingling, or swelling of lips, tongue mouth _____		
Skin: hives, itchy rash, swelling of the face or extremities _____		
Gut: nausea, abdominal cramps, vomiting, diarrhea _____		
Throat *: Tightening of throat, hoarseness, hacking cough _____		
Lung*: Shortness of breath, repetitive coughing, wheezing _____		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other: _____		
If reaction is progression (several of the above areas affected):		

\*Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine:** inject intramuscularly:

EpiPen® \_\_\_\_\_ EpiPen JR® \_\_\_\_\_ Auv-i-Q \_\_\_\_\_  
 or generic \_\_\_\_\_ or generic \_\_\_\_\_

**Antihistamine:** give \_\_\_\_\_

**Other:** give \_\_\_\_\_

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## STEP2: EMERGENCYCALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

\_\_\_\_\_  
 Doctor's Name \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_  
 \_\_\_\_\_  
 Parent's Name \_\_\_\_\_ Parent's Phone Number \_\_\_\_\_  
 \_\_\_\_\_  
 Emergency Contact 1 Name/Relationship \_\_\_\_\_ Emergency Contact 1 Phone Number \_\_\_\_\_

**EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

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

## Student Medications Policy and Procedure

**Parents: please read the following and sign below. Return with Physician's Medication Form.**

### Policy

1. The Banner School will dispense to students only those medications deemed appropriate and prescribed by a licensed physician or nurse practitioner.
2. The Banner School will not dispense any medications or change any dosages or administration times unless authorized in writing by a licensed physician or nurse practitioner.
3. The Banner School does not assume any responsibility for medication that is not prescribed by a licensed physician or nurse practitioner and/or any medication in a student's possession of which the school is unaware.
4. Other than administering the dose at the correct time, The Banner School does not assume responsibility for why a drug is administered, for monitoring its action or any side effects or adverse reactions caused by the drug or combination of drugs that may be administered.
5. Any prescription and non-prescription medication needed on a field trip must have a completed medication order form. The order form and medication must be brought into the front office by a parent no later than five school days before the field trip.

### Procedure

1. A Physician's Authorization for Prescription and Non-prescription Medication Form must be filled out and signed by a licensed physician or nurse practitioner for every prescription and non-prescription drug that a student may need to take during the course of the school day and on field trips. Parents are not to complete Part II, only a physician.
2. Parents must bring the completed Physician's Medication Form and the medicine in its original and properly labeled container to the school. The pharmacy label must match the Physician's Medication Form.
3. The delegating nurse will check the drug container and the Medication Form to be sure it is filled out completely. Any drug that is not in a properly labeled, original container, and any form that is illegible or not filled out completely will be returned to the parent. It is the responsibility of the parent to be sure the drug is in the appropriate container and to return the form to the physician so that it is filled out completely and correctly.
4. The drug container will be placed in a locked area. The Physician's Medication Form will be placed in the student's medication file.
5. The first dose of any newly prescribed medication must be given at home.
6. The school receptionist will dispense the drug to the student at the designated time. All doses administered are recorded on an administration sheet labeled with the student's name. If the dose is missed, the school receptionist will notify the parent.
7. When the prescribed number of doses have been administered, the school receptionist will indicate this on the administration form and return the empty drug container to the parent. All Physician's Medication Form and drug administration records are retained by the school.
8. All unused and/or unclaimed medication will be destroyed the day after the last day of school.

**I understand and agree with the above policy and procedures so that my child can receive his/her medication at The Banner School.**

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_