Medical Form Packet

If your child will be taken any medication at camp or has a medical problem that the camp nurse should be aware of, Please complete the following forms.

Please bring forms and medicine to the camp trailer on the first day of camp. Staff will be available that day starting at 8:30 a.m.

Please make sure all forms are filled out properly and are signed by your physician.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the New Jersey State Law and Regulations require an authorized prescriber (M.D., P.A. or APRN) or dentist's written order AND parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the medication, strength, dosage, frequency, authorized prescriber or dentist's name and date or original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER:

Date of Order: _____

Name of Child: _____ Date of Birth: ___/___/___

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Condition for which the medication is being administered during camp hours:

_____

Medication: Name of medication, dosage and method of administration:

_____

Times of administration: _____ Medication shall be administered from: __/__/__ through __/__/__

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled medication? _____

Allergies, reaction to, or negative interaction with food and drugs? If yes, list:

_____

AUTHORIZED PRESCRIBER'S OR DENTIST'S INFORMATION (PLEASE PRINT):

Authorized Prescriber's of Dentist's Name: _____ Telephone number: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Authorized Prescriber's or Dentist's Signature: _____ Date: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR ADMINISTRATION OF ABOVE MEDICATION

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child, _____, be administered by the nurse or camp personnel with current Medication Administration Training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following the termination of the order.

Parent/Guardian Name: _____

Relationship to Camper: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Parent/Guardian Signature: _____ Date: _____ Emergency Phone Number: _____

SELF ADMINISTERED INHALER/EPIPEN OR MEDICATION FOR LIFE THREATENING ILLNESS

This is only for life threatening illnesses, not over the counter medications!

A camper may be permitted to self-administer a medication for a life threatening allergy or illness. The parent must understand that the camp will not accept any responsibility for injury arising from the self medication and sign the following statement to that effect. I hereby give permission for my child, _____, to self-administer _____, which is a medication required for the following medical condition _____. My child is capable of, and has been instructed in the proper administration of the required medication. I understand that the 4th and Inches Football Camp will not be held responsible for any injury arising from self-administration.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
Original PACNJ approved Plan available at www.pacnj.org

Asthma Treatment Plan Patient/Parent Instructions

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

1. Patients/Parents/Guardians: *Before taking this form to your Health Care Provider:*
Complete the top left section with:
- Patient's name
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- An Emergency Contact person'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 circle 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 you or your child to follow

3. Patients/Parents/Guardians & Health Care Providers together:
Discuss and then complete the following areas:
- Patient's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Patient's asthma triggers on the right side of the form
- For Minors Only 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

This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-1, XA98284401-3 and XA97250908-0 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

AMERICAN LUNG ASSOCIATION. of New Jersey

Asthma Treatment Plan

(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"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY

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 medicine(s). All metered dose inhalers (MDI) to be used with spacers.

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

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

CAUTION

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

And/or Peak flow from_____ to_____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 4 hours as needed
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	

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

EMERGENCY

Your asthma is getting worse fast:
- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Chalk dust
- ❑ Cigarette Smoke & second hand smoke
- ❑ Colds/Flu
- ❑ Dust mites, dust, stuffed animals, carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests - rodents & cockroaches
- ❑ Pets - animal dander
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfumes, cleaning products, scented products
- ❑ Sudden temperature change
- ❑ Wood Smoke
- ❑ Foods:

_____
_____
_____

- ❑ Other:

_____
_____
_____
_____
_____

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

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EFFECTIVE MARCH 2008

Permission to reproduce blank form
Approved by the New Jersey Thoracic Society

FOR MINORS ONLY:

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

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

ALLERGY ACTION PLAN

Freehold Township Summer Camp 2025

Camper's Name: _____ Birthday: _____

ALLERGY TO:_____

Type of reaction in the past (please circle) cutaneous respiratory eye/nasal cardiac Gastrointestinal Other-please specify _____

Date of Reaction _____ Anaphylaxis YES ☐ NO ☐ Hospitalized YES ☐ NO ☐

If anaphylactic to a food, camper should only consume food or drinks provided by parent/guardian.

Skin Testing YES ☐ NO ☐ In Vitro Testing YES ☐ NO ☐

Asthmatic *YES ☐ NO ☐ **Higher risk for severe reaction ☐ Child must wear MEDICAL ALERT bracelet

Place Child's Picture Here

♦ STEP 1: TREATMENT ♦

Symptoms:		Give Checked Medication**:	
• If a food allergen been ingested, but *no symptoms:*		☐ EpiPen	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
• Throat+	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
• Lung +	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
• Heart +	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
• Other +	_____	☐ EpiPen	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

May Repeat x _____ every _____ (In absence of a nurse, a trained delegate may give epinephrine only for a multisystem reaction. Delegates may not administer antihistamine.)

Antihistamine: Give Diphenhydramine PO ☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ Other_____
Medication/route/dose

Other: _____
Medication/route/dose

♦ STEP 2: EMERGENCY CALLS ♦

1. Call 911 and state that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Call Parent/Guardian _____ at _____ or _____
   _____ at _____ or _____

EVEN IF PARENT/GUARDIANCANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Doctor's Signature _____ Date _____ Office Stamp ☐

I hereby request that the nurse administer the above medication as directed by my physician to my child. I will supply medication in the ORIGINAL CONTAINER and will notify the nurse promptly of any change in this order.

Parent/Guardian Signature _____ Date _____

Epinephrine Delegate Authorization Form

Child's Name: _____

I, _____, parent/guardian of the above named child, give authorization for a properly trained delegate to administer epinephrine via pre-filled auto injector mechanism in an emergency and/or in the event that the camp nurse is unavailable during an anaphylaxis reaction.

_____ _____
Parent/Guardian Signature Date

This authorization is valid from June 30, 2025 through August 15, 2025.

By signing this authorization, Freehold Township Parks and Recreation Summer Camp shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto injector mechanism to the above named child and that the parent/guardian shall indemnify and hold harmless Freehold Township Parks and Recreation Summer Camp and its employees or agents any claim arising out of the administration of epinephrine via a prefilled auto injector mechanism.

_____ _____
Parent/Guardian Signature Date

Refusal for Epinephrine Delegate

Child's Name: _____

I, _____, parent/guardian of the above named child waive my right to have a properly trained delegate administer epinephrine via pre-filled auto injector mechanism or the child's self –administration of epinephrine via a pre-filled auto injector mechanism as ordered by my prescriber (MD, DO, ANP).

_____ _____
Parent/Guardian Signature Date