Please note:

The following pages titled, "Asthma Action Plan",

do NOT need to be filled out and returned to the camp office unless you plan to send an Inhaler or some other type of asthma medication to camp for your child.

If your child will be bringing an Inhaler or some other type of asthma medication to camp, please complete the **ASTHMA ACTION PLAN** form (two pages) as well as the **MEDICATION AUTHORIZATION FOR EMERGENCY MEDICATIONS** form and submit to the camp office asap.

ALL MEDICATIONS, INCLUDING INHALERS, must be in the original or a duplicate box with the current prescription label on the container, accompanied by the completed forms. (Upon request, pharmacists will label containers that are missing labels.) Inhalers without this information will be returned to you for compliance.

HAVE YOUR PHYSICIAN COMPLETE BOTH FORMS and sign as applicable. The forms should be submitted to the camp office two weeks prior to the arrival of your child and your child's medication.

Your permission and signature are also required.

All medications must be dropped off in the CAMP OFFICE (including Emergency Medications) immediately upon arrival**.**

ASTHMA ACTION PLAN ~ PAGE 1

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

Please complete this form if the camper has an inhaler or other asthma-related medication. We do not supply any over-the-counter medications. You MUST send medication to camp in the original or a duplicate box or bottle with the current prescription label on the container, accompanied by this completed form. THIS INCLUDES INHALERS!!! (Upon request, pharmacists will label containers that can be used.) HAVE YOUR PHYSICIAN COMPLETE THIS FORM AND SIGN IT IN BOTH PLACES AT THE BOTTOM. This form should be submitted to the camp office prior to the arrival of your child's medication. Your permission and signature are also required with any medication. All forms and medication, including INHALERS must be dropped off in the CAMP OFFICE!

Name of Camper (First, Middle Initial, Last):	D.O.B (mm/dd/yyyy):	Peak Flow Personal Best:

Asthma Severity (Check one): ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

Asthma Triggers (Check all that apply): ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other _____

This Asthma Action Plan shall be effective for and medication shall be administered: (not to exceed 1 year)	From (mm/dd/yyyy):	To (mm/dd/yyyy):

GREEN ZONE - DOING WELL

You have **ALL** of these:

Breathing is good
No cough or wheeze
Can walk, exercise & play
Can sleep all night

If known, peak flow greater than _____ (80% personal best)

Medication Name:	Dose:	Route:	Frequency:	OK to Self-Administer?
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

EXERCISE ZONE

☐ Prior to all exercise/sports
☐ When the child feels they need it

Rescue Medication:	Dose:	Route:	Frequency:	OK to Self-Administer?
				☐ Yes ☐ No
	Known side effects:			

YELLOW ZONE - GETTING WORSE / CAUTION

You have **ANY** of these:

Some problems breathing
Wheezing, noisy breathing
Tight chest
Cough or cold symptoms
Shortness of breath
Other: _____

If known, peak flow between _____ and _____ (50% to 79% personal best)

Emergency Medication Name:	Dose:	Route:	Frequency:	OK to Self-Administer?
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

RED ZONE - MEDICAL ALERT / DANGER / EMERGENCY / CALL 911

You have **ANY** of these:

Breathing hard and fast
Lips or fingernails are blue
Trouble walking or talking
Medicine is not helping (15-20 mins?)
Other: _____

If known, peak flow below _____ (0% to 49% personal best)

Emergency Medication Name:	Dose:	Route:	Frequency:	OK to Self-Administer?
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

ASTHMA ACTION PLAN ~ PAGE 2

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

Parent/Guardian: Please complete this form if the camper has an inhaler or other asthma-related medication. We do not supply any over-the-counter medications. You MUST send medication to camp in the original or a duplicate box or bottle with the current prescription label on the container, accompanied by this completed form. THIS INCLUDES INHALERS!!! (Upon request, pharmacists will label containers that can be used.) HAVE YOUR PHYSICIAN COMPLETE THIS FORM AND SIGN IT IN BOTH PLACES AT THE BOTTOM. This form should be submitted to the camp office prior to the arrival of your child's medication. Your permission and signature are also required with any medication. All forms and medication, including INHALERS must be dropped off in the CAMP OFFICE! Inhalers are not carried by campers, rather they are placed in an Adult Counselor's bag to be brought along to all activities at all times for the group the camper is placed in. The bag will be locked in the camp office each night and returned to the camper's group each morning.

Name of Camper (First, Middle Initial, Last):	D.O.B (mm/dd/yyyy):

PRESCRIBER'S AUTHORIZATION			
Prescriber's Name & Title:			This space may be used for the Prescriber's Address Stamp
Telephone	Fax		
Address			
City	State	Zip Code	
Prescriber's Signature (NOT Valid if Parent/Guardian Signs here)			Date (mm/dd/yyyy):

PRESCRIBER'S AUTHORIZATION FOR SELF-ADMINISTRATION (Supervised by a camp staff member)

This section should be completed if any medications in the attached Asthma Action Plan on page 1 are approved for self-administration. It's All Fun & Games LLC camp does not permit self-carry of any medication. Inhalers & other emergency type medications are placed in a bag specific to the camp group the camper is placed in. That bag is carried by the Adult Counselor who is specifically responsible for that camper's group and is brought to ALL of the camper's activities at all times. The bag is placed in the locked camp office each evening and returned to the group each morning. All other medications are stored in a locked cabinet in the camp office.

Prescriber's Signature for Self-Administration of medications as noted on page 1	Date (mm/dd/yyyy):

PARENT / GUARDIAN AUTHORIZATION

I authorize self-administration of the medication listed above, for the child named above, under the supervision of a designated staff member at It's All Fun & Games, LLC. I request the authorized youth camp operator or designated staff member at It's All Fun & Games, LLC, supervise the camper in self-administration as prescribed above by the authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including self-administration of the medication at the facility. I understand at the end of the authorized period, an authorized individual must pick up the medication; otherwise it will be discarded. I authorize camp personnel to communicate with the authorized prescriber indicated on this form in compliance with HIPAA.

Parent / Guardian Signature:	Date (mm/dd/yyyy):	Other individuals Authorized to pick up medication:
Home Phone	Cell Phone	Work Phone

PARENT / GUARDIAN'S AUTHORIZATION FOR SELF-ADMINISTRATION (Supervised by a camp staff member)

This section should be completed if any medications in the attached Asthma Action Plan on page 1 are approved for self-administration. It's All Fun & Games LLC camp does not permit self-carry of any medication. Inhalers & other emergency type medications are placed in a bag specific to the camp group the camper is placed in. That bag is carried by the Adult Counselor who is specifically responsible for that camper's group and is brought to ALL of the camper's activities at all times. The bag is placed in the locked camp office each evening and returned to the group each morning. All other medications are stored in a locked cabinet in the camp office.

Parent / Guardian's Signature for Self-Administration of medications as noted on page 1	Date (mm/dd/yyyy):

MEDICATION AUTHORIZATION
FOR EMERGENCY MEDICATIONS
(EPI-PENS & EMERGENCY INHALERS)

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

This form must be completed fully in order for your child to have or receive EMERGENCY MEDICATIONS (such as Epi-pens & Emergency Inhalers) at camp, We must have specific directions for each medication AND self-administration authorization (except for Emergency Medications) from a physician which includes a physician's signature AND a parent signature. It is required that the first dose of any medication (except for Emergency Medications) be administered at home. All medications must be self-administered by the camper (except for Emergency Medications); including the ability to determine the correct amount and requires Authorization for Self-Administration/Signatures from both a parent and a physician. A responsible camp staff person will observe and supervise the child during the process of self-administration. If you do not feel the child can self-administer medication, the medication can NOT be brought to camp.

We do not supply any over-the-counter medications. You MUST send medication to camp in the original or a duplicate box or bottle with the current prescription label on the container, accompanied by this completed form. (Upon request, pharmacists will label containers that can be used.) HAVE YOUR PHYSICIAN COMPLETE THIS FORM AND SIGN IT AT THE BOTTOM. YOU MUST ALSO SIGN THIS FORM. This form should be submitted to the camp office in advance of your child's arrival and prior to the arrival of the medication.

All medications (including Emergency Medications) must be dropped off in the CAMP OFFICE immediately upon arrival of camper!

PHYSICIAN'S INSTRUCTIONS FOR MEDICATION AT CAMP

Name of Camper _____ D.O.B. _____

Camper Address _____

Parents Primary Phone _____ Parent's Alternate Phone _____

Date of Commencement _____ Date of Discontinuation _____

Medication Name _____ Medication Dosage _____

Frequency of Administration _____ Route of Administration _____

If PRN, the frequency and for what symptoms should the medication be administered _____

This medication is to be used for emergency situations Y N

Condition for which medication is being administered _____

If side effects or a reaction can be expected, please describe _____

_____

Please PRINT below the Physician's / Prescriber's Name, Title, Address, Phone Number and Fax Number:

_____ _____

_____ _____

_____ _____

_____ _____

Physician's / Prescriber's Signature _____Date _____

Parent's Signature _____ Date _____

AUTHORIZATION FOR SELF-ADMINISTRATION

I authorize self-administration of the medication listed above, for the child named above, under the supervision of a designated staff member at It's All Fun & Games, LLC. I request the authorized youth camp operator or designated staff member at It's All Fun & Games, LLC, supervise the camper in self-administration as prescribed above by the authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including self-administration of the medication at the facility. I understand at the end of the authorized period, an authorized individual must pick up the medication; otherwise it will be discarded. I authorize camp personnel to communicate with the authorized prescriber indicated on this form in compliance with HIPAA.

Physician's / Prescriber's Signature _____Date _____

Parent's Signature ____ Date ____________________________

MEDICATION FINAL DISPOSITION

IT'S ALL FUN & GAMES, LLC 1810 Valleybrook Dr Kingsville MD 21087

Parents, please complete only the Camper Information section of this page!

CAMPER INFORMATION

Name of Camper _____ D.O.B. _____

Camper Address _____

_____

Parent / Guardian's Primary Phone

_____

Parent/Guardian's Alternate Phone

_____

The bottom of this page is for camp staff use only.
Parents, please leave the following bottom section BLANK:

CAMP STAFF: COMPLETE AT END OF SESSION

1) Name of Medication (Listed on Reverse) _____

2) Date of Final Disposition of Medication Listed on Reverse _____

3) This medication was returned to the parent or guardian (Circle one) Y N (If No, skip Items #4 & #5, then go to #6)

4) Name of the person to whom the medication was returned _____

5) Name of the Camp Staff Member who returned the medication _____

6) Signature of the Camp Staff Member responsible for returning or destroying the medication

_____ Date _____

7) Signature of the Person Witnessing the Destruction of the Medication

_____ Date _____