Rising Star Camp 2024 Required Forms

We are very excited for Rising Star Camp 2024!

Please read the information below carefully to properly register camper(s) for Rising Star Camp.

The following forms **must be completed and returned** to both RSC Camp Directors listed below ***prior to your child's first session***. Children are not permitted to attend unless completed forms are submitted.

Forms may be printed and submitted through email by scanning the form or by taking a clear picture of the form. ***If you are submitting the completed forms through email, please make sure to include both RSC Camp Directors listed below.***

Electronic versions of the forms are available. You may fill out the forms online, save the document, and email it to ***both*** RSC Camp Directors.

REQUIRED FORMS:

- **Camper Questionnaire**
- **Individual Plan of Care for Child**
- **Health History & Physician's Exam Form -** ***(to be completed by parent & camper's physician)***
- **Asthma Care Plan Form -** *(If your child has asthma, please complete this form)*
- **Allergy Emergency Care Plan** *- (If your child has allergies, please complete this form)*
- **Medication Administration Plan Form** *– (If your child needs medication administered at camp, please complete this form)*

If you need assistance or have any questions, please contact the RSC Camp Directors listed below.

RSC Camp Directors

Julissa Martinez
860-944-7867
jmartinez@nwcty.org

Juliana Lee
860-463-6629
jlee@nwcty.org

CAMPER QUESTIONNAIRE

Camper's Name: Last _____ First _____

Grade Entering: _____ Age _____

By providing honest input concerning your camper's emotional, physical and social needs, you help us ensure that he/she has **The Best Summer Ever**! Forms are confidential and are reviewed by staff working with your child. Please complete page one of the Camper Questionnaire and please work with your camper to complete the camper section on the back. Please use additional paper if necessary. This completed form should be returned **one week before your camper starts at camp!** As many things change in a camper's life, previous forms are not retained.

Pertinent information regarding child: (i.e. parental status, major life changes, family members living elsewhere, new siblings, etc.) _____

_____

Does your camper have any concerns regarding camp? Please describe: _____

_____

Do you, as parents or guardians, have any concerns regarding camp? Please describe: _____

_____

_____

Does your camper have any learning or physical limitations? Please describe: _____

_____

_____

Is your camper highly competitive? _____

_____

What have you found to be the most effective form of behavior management? _____

_____

What do you most want out of camp for your child? _____

_____

_____

How may we enhance your child's experience at camp? _____

_____

_____

Is there anything else you would like to share? _____

_____

CAMPER'S SECTION

Ask Your Camper

Camper's Name: _____

Last First

Please spend a few moments with your camper and ask him/her to share answers to these questions. Older campers may complete this form by themselves.

What would you like other campers and staff to call you? _____

What three things do you most want to accomplish while you are at camp?

1. _____

2. _____

3. _____

Are there any things that concern you about coming to camp? _____

_____

What are your hobbies/interests? _____

Do you have any special talents? _____

_____

While you won't meet your counselors until you get to camp, if you had a question to ask them now, what would that be?

_____

Because we would like to know you better, is there anything else you'd like to share?

_____

Thanks for taking time to fill this out!

If filling out form outline please email to risingstar@nwcty.org
If completing paper form you may scan or take a clear picture of the form and email to risingstar@nwcty.org or drop at the Torrington or Winsted YMCA.

RSC 2024 Camper
Individual Care Plan

Child's Name_____ **D.O.B**___/_____/____

Sessions Attending: ☐ **Session 1** *(6/26-7/7)* ☐ **Session 2** *(7/10-7/21)*

☐ **Session 3** (*7/24-8/4)* ☐ **Session 4** *(8/7-8/18)*

Special Health / Behavioral Concerns
If necessary, please specify on the line provided.

Yes	No	
☐	☐	Allergies (food, medication, insects, environmental, etc.) _____
☐	☐	Asthma _____
☐	☐	Vision / Hearing / Speech (glasses, ear tubes, etc.) _____
☐	☐	Chronic Illness _____
☐	☐	Diabetes _____
☐	☐	Seizures _____
☐	☐	Dietary Needs _____
☐	☐	Developmental Variations _____
☐	☐	Emotional / Behavioral _____
☐	☐	IEP or 504 Plan ***- If selected yes, please attach a copy to this form.*** _____
☐	☐	Other _____

Symptoms / Medication / Process of Care
*For each **"Yes"** answer listed above, please provide the following information.*

#1 Health Concern: _____

Symptoms: _____

On-Site Medication: ☐ Yes ☐ No _____

Steps of Care: _____

1. _____

2. _____

3. _____

4. _____

Additional Information: _____

Continue on next page ➡

RSC 2024 Camper
Individual Care Plan

Child's Name_____ **D.O.B**___/_____/____

Sessions Attending: ☐ **Session 1** *(6/26-7/7)* ☐ **Session 2** *(7/10-7/21)*

☐ **Session 3** (*7/24-8/4)* ☐ **Session 4** *(8/7-8/18)*

#2 Health Concern: _____

Symptoms: _____

On-Site Medication: ☐ Yes ☐ No _____

Steps of Care: _____

1. _____
2. _____
3. _____
4. _____

Additional Information: _____

#3 Health Concern: _____

Symptoms: _____

On-Site Medication: ☐ Yes ☐ No _____

Steps of Care: _____

1. _____
2. _____
3. _____
4. _____

Additional Information: _____

Name of Health Care Provider:_____ **Phone:** (_____)_____

Parent / Guardian Signature: _____ **Date:** _____

Parent / Guardian Signature: _____ **Date:** _____

If filling out form outline please email to risingstar@nwcty.org
If completing paper form you may scan or take a clear picture of the form and email to risingstar@nwcty.org or drop at the Torrington or Winsted YMCA.

RSC 2024 Camper
Individual Care Plan

Child's Name_____ **D.O.B**___/_____/____

Sessions Attending: ☐ **Session 1** *(6/26-7/7)* ☐ **Session 2** *(7/10-7/21)*

☐ **Session 3** (*7/24-8/4)* ☐ **Session 4** *(8/7-8/18)*

***** For Administrative Use Only *****

Camp Director: _____ ***Signature***: _____Date: _____

Camp Director: _____ ***Signature***: _____Date: _____

Water Front Director: _____ ***Signature***: _____Date: _____

First Aid Director: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Group Counselor: _____ ***Signature***: _____Date: _____

Rising Star Camp

Health History & Physician's Exam Form

This form must be received two weeks prior to camp. **Children are not permitted to attend unless form is complete**. Everyone must submit an updated form each summer. This side to be completed by parent/guardian of minor or by adult camper/staff.

Return To: WYSB/ Rising Star Camp
NWCTY
480 Main St.
Winsted. CT 06098

Telephone: (860) 379-0708/Fax: 1-877-802-8496

Name_____ DOB_____ Sex____ Age_____
Last First Initial

Address_____ Phone_____

City_____ State_____ Zip Code_____

Mother's Name_____
(or Guardian)
Employer_____ Phone_____

Father's Name_____
(or Guardian)
Employer_____ Phone_____

If parents do not live together, camper lives with: _____ Mother _____ Father _____Guardian

Address of non-custodial parent_____ Home Phone_____

MEDICAL INSURANCE _____
Carrier Name

Policy/Group#_____

For Female Camper—
Menstruation started: yes/no
Has understanding of: yes/no
Special Consideration_____

Physician_____ **Phone**:_____

Dentist_____ **Phone**:_____

Health History (Check/Dates)

Frequent Ear Infections_____
Heart Defect/Disease_____
Convulsions_____
Diabetes_____
Bleeding/Clotting Disorders_____
Hypertension_____
Mononucleosis_____
Chicken Pox_____
Measles_____
German Measles_____
Mumps_____

Allergies—Please Describe:
Plants_____
Insects_____
Medication_____
Food_____
Other_____

Has this camper ever been stung by a bee? If yes, describe reaction and treatment, if any:

_____

Does this camper have asthma? If yes, please describe treatment:

_____

Has this camper every received psychiatric counseling?_____

Operations or serious injuries (dates):_____

Current Medications:_____

Dietary Restrictions:_____

Other details, instructions, or recommendations:_____

*****IMPORTANT***Below must be completed and signed for attendance*****

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for me/or my child as named above. This form may be photocopied for use out of camp.

Signature (parent/guardian)_____ Date_____

IMMUNIZATION HISTORY
Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1.	1.
Pertussis (Whp. Cough) DPT*	2.	2.
Tetanus	3.	3.
Or		
Tetanus Diphtheria TD*		
Or		
Tetanus Oral Polio (Sabin)*TOPV		
Injectable Polio (Salk)		
Measles (hard, red, Rubeola)		
Mumps		
Rubella (German, 3-day)		
Other		
Tuberculin Test	Given (most recent)	
Haemophilius influenza b (HIB)		
Hepatitis B (HBV)		

HEALTH EXAM BY LICENSED PHYSICIAN:

I have examined the named camp applicant within the past **three** years. Date examined:_____
In my opinion, the applicant's condition does/does not preclude his/her participation in an active camp program.

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____

The applicant is under the care of a physician for the following conditions:_____

_____

Current Treatment (include current medications):

_____

Explanation of any reported loss of consciousness, convulsion, or concussion:

_____

Does applicant have epilepsy? YES_____ NO_____ Does applicant have diabetes? YES_____NO_____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp:

_____

Any medication to be administered at camp (specific dosages):

_____

Any medically prescribed meal plan or dietary restrictions:

_____

Any allergies (food, drug, plants, insects, etc.):

_____

Additional Health Information:

Licensed Physician's Signature_____ Phone_____

Address_____

Date form completed_____ *By_____

*Initial if completed by nurse or physician's assistant

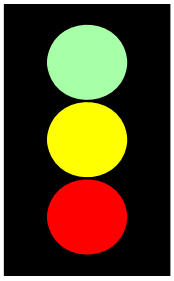
Asthma Action Plan
Ages 0 – 11 Years

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
www.ct.gov/dph/asthma

Name:	Birth Date:	Date:
Parent/Guardian Phone #'s:	Provider Phone #: Fax #: (or stamp)	

Important! Things that make your asthma worse (Triggers): ☒ smoke ☐ pets ☐ mold ☐ dust ☐ tree/grass/weed pollen ☐ colds/viruses ☐ exercise ☐ seasons: other:

Severity Classification: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Intermittent



GO – You're Doing Well!

USE THESE MEDICINES EVERY DAY TO PREVENT SYMPTOMS

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

Peak Flow may be useful for some kids.

CONTROLLER MEDICINE _____ **DIRECTIONS** _____

_____ _____

_____ _____

☐ **If your child usually has symptoms with exercise then give:**

_____ _____

☺ **Inhalers work better with spacers. Always use with a mask when prescribed.**

CAUTION – Slow Down!

Continue with Green Zone Medicine and Add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

RESCUE MEDICINE _____ **DIRECTIONS** _____

_____ _____

Then: Wait **20 minutes** and see if the treatment(s) helped
- If you are **GETTING WORSE** or **NOT IMPROVING** after the treatment(s) **GO TO RED ZONE**
- If you are **BETTER,** continue treatments every 4 to 6 hours as needed for 24 to 48 hours

Then: If you still have symptoms after 24 hours, CALL YOUR DOCTOR and if he/she agrees:
- Start: _____

If rescue medication is needed more than 2 times a week, call your doctor at: _____

DANGER – Get Help!

TAKE THESE MEDICINES AND SEEK MEDICAL HELP NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

RESCUE MEDICINE _____ **DIRECTIONS** _____

_____ _____

Then: Wait 15 minutes and see if treatment helped
- If **GETTING WORSE** or **NOT IMPROVING**, go to the hospital or **call 911**
- If you are getting **BETTER**, continue treatments every 4 to 6 hours and call your doctor – **say you are having an asthma attack and need to be seen TODAY!**

Then: **If your doctor agrees, start:** _____

✓ Make an appointment with your primary care provider within two days of an emergency visit, hospitalization, or anytime for ANY problem or question with asthma

School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

Parents: Call your doctor for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR _____ as stated *in accordance with CT State Law and Regulations 10-212a*

Self–Administration: ☐ This student is capable to safely and properly self-administer this medication OR ☐ This student is not approved to self-administer this medication

Signature:_____ Provider Printed Name:_____ Date:_____ For use from _____ to _____

Parent/Guardian Consent: REQUIRED

☐ I authorize this medication to be administered by school personnel OR ☐ I authorize the student to possess and self-administer medication.

I also authorize communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of this medication.

Parent/Guardian Signature: _____ Date: _____

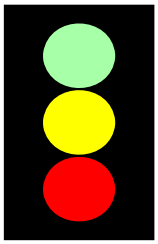
* Bring asthma meds and spacer to all visits

Plan de Acción Contra el Asma

Niños 0 – 11 años

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
www.ct.gov/dph/asthma

Nombre de paciente:	Fecha de nacimiento:	Fecha:
# teléfono del Padre/Guardián:	# teléfono del Médico: # fax:	
¡Importante! Cosas que hace peor el asma: □ humo □ mascotas □ moho □ polvo □ polen de árbol/hierba □ resfriado/virus □ ejercício □ cambio de clima: □ otras cosas:		



Clasificación de Severidad: □ Severo persistente □ Moderado persistente □ Leve persistente □ Leve Intermitente

Proceda – ¡Está haciendo bien!

USE ESTAS MEDICINAS CADA DÍA PARA PREVENIR SÍNTOMAS

Usted tiene *todos* estos sintomas:

- Respira bien
- No hay tos o sibilancias
- Duerme toda la noche
- Puede trabajar y jugar

Información sobre flujo máximo podría ser útil para niños que no perciben bien sus síntomas.

MEDICINA DE CONTROL	COMO DEBERÍA TOMARLA
_____	_____
_____	_____

☐ **Si por lo general su niño tiene síntomas de asma durante el ejercicio, déle:**

_____ _____

☺ **Inhaladores funciona mejor con un espaciador.**
Siempre use con el espaciador con mascarilla o boquilla.

PRECAUCIÓN – ¡Detengase! Continúe con medcina de la Zona Verde y Añade:

Si tiene estos sintomas:

- Síntomas iniciales del resfriado
- Contacto con alguna cosa que provoca asma
- Tos
- Sibilancia
- Pecho apretado
- Tos por la noche

MEDICINA DE RESCATE	COMO DEBERÍA TOMARLA
_____	_____

Entonces: Espere 20 minutos y evalúe si el tratamiento ayudó

- Si **ESTÁ EMPEORANDO** o **NO HAY MEJORÍA** después del tratamiento, **PROCEDA A LA ZONA ROJA**
- Si **HAY MEJORÍA**, continúe con la medicina en dosis indicada cada 4 a 6 horas como necesario durante 24 a 48 horas

Entonces: Si todavía tiene síntomas despúes de 24 horas, LLAME A SU MÉDICO. Si él/ella está de acuerdo:

- Empiece: _____

Si necesita medicina de rescate más que dos veces en una semana, llame a su médico: _____

PELIGRO – ¡Obtenga ayuda! TOME ÉSTAS MEDICINAS Y COJA AYUDA MEDICA AHORA MISMO!

Rápidamente, su asma <u>está empeorando</u>:

- La medicina no le ayuda
- Respiración es difícil y rápido
- Las fosas nasales se abre ancha
- No puede hablar bien
- Se pone nervioso

MEDICINA DE RESCATE	COMO DEBERÍA TOMARLA
_____	_____

Entonces: Espere 15 minutos y evalúe si el tratamiento ayudó

- Si **ESTÁ EMPEORANDO** o **NO HAY MEJORÍA**, vaya al hospital o **llame 911**
- Si **HAY MEJORÍA**, continúe con la medicina en dosis indicada cada 4 a 6 horas y llame a su médico – **Dígale que está teniendo un ataque de asma y necesita una cita HOY!**

Entonces: Si él/ella está de acuerdo, empiece: _____

✓ Haga una cita con su proveedor de cuidado primario dentro de dos días a partir de una visita al ED o una hospitalización, o en cualquier momento para cualquier problema o pregunta sobre asma.

School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

Padre/Guardián: Llame al médico para discutir preguntas sobre control del asma o si uso de medicina de rescate es más que 2 veces/semana

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR _____ as stated *in accordance with CT State Law and Regulations 10-212a*

Self–Administration: ☐ This student <u>is</u> capable to safely and properly self-administer this medication OR ☐ This student <u>is not</u> approved to self-administer this medication

Signature:_____ Provider Printed Name:_____ Date:_____ For use from _____ to _____

Padre/Guardián: OBLIGATARIO

☐ Autorizo al empleados medicos de la escuela para dar estas medicinas a mi niño/a O ☐ Autorizo al estudiante para tener estas medicinas y tomárselas a si mismo

Autorizo también la comunicación, entre el médico que prescribe las medicinas, la enfermera escolar, el consejero médico escolar, y professionales de clínica basados en la escuela que es necesario para el manejo de asma y administración de estas medicinas.

Firma del Padre/Guardián: _____ Fecha: _____ Traiga medicinas para asma y espaciador a todas citas.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens:_____

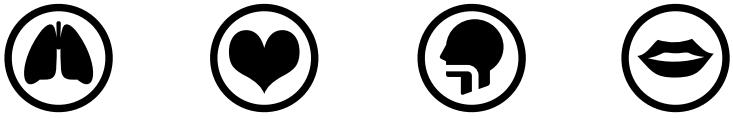
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

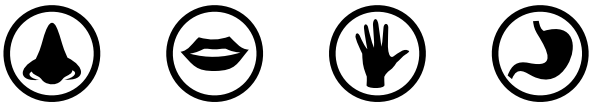
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

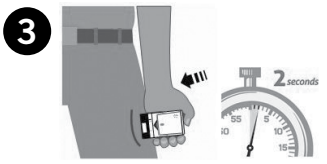
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

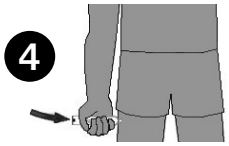
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



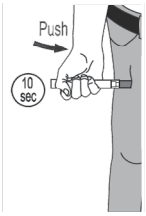
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

****

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student_____ Date of Birth _____/_____/_____

Pharmacy Name _____ Prescription Number _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ Date _____/_____/____