UCP Camp Harkness 2018

Packet #3
Medical Forms

In this packet, you'll find these 7 forms:

- Instructional Information
- Physical and Medical Information
- Medication Administration Instructions
- Physician Order to receive Potassium Iodide Tablet
- Medication Orders
- Non-essential Medication Temporary Hold Orders
- PRN Physician Order Sheet

Please remember that we can only accept medical forms that are originals or faxed directly from the physician's office to the camp coordinator.

Packets #2 and #3 must be completed and returned no later than April 1, 2018.

Failure to submit Packets #2 and #3 by April 1st will result in a loss of session reservation and the camper will be put on our waiting list. Campers requesting an exception to the April 1st due date should contact Cheryl Scott @ 860-712-9444. Campers who have a yearly physical date which occurs after April 1st will be granted an exception.

Dear Camper,

We are all very excited about this year's camp sessions and are looking forward to a wonderful summer!

In an effort to streamline our medication administration times and allow campers more time to enjoy participating in activities, we are making some requests regarding medication orders.

We are requesting that medications that are not essential be placed on hold for the duration of the camp session.

Please check with your provider to see if there are non-essential medications that can be placed on hold.

Examples of these types of medications could include:

- Vitamins
- Lotions/creams/treatments that are not treating or preventing an acute condition

In addition to the holding of non-essential medications, **we would like to encourage the packaging of medications in "Dispill/vacation packs." These pill packs allow for multiple medications to be packaged together in one blister allowing for easier and efficient medication administration.**

An example of these pill packs is on the following page in color. Most commercial pharmacies offer this packaging service.

Please note: If a Physician's Order changes, the pill pack(s) need to reflect this change. If a medication is D/C'd after the pack(s) have been filled, they will need to be repackaged.

We greatly appreciate everyone's attention in these matters and are looking forward to the upcoming camp season!

DISPILL

Greetings Campers,

In this packet you will find our UCP Camp Harkness Doctor's Orders. These forms are meant to be user friendly.

When completing the camp forms this year, please have the person most familiar with the doctor's orders and medical information fill them out to the best of their ability prior to the appointment with the doctor so physician will need only to review the orders, sign and date (in addition to any physical that may need to be completed). Our experience has been that UCP Campers have many physicians and many medications. Those who care for the Campers at home often know the current orders and dosages sooner than the primary doctor. As always, signed and dated original orders (or orders faxed directly from the doctor's office) should accompany any Camper if there have been changes to his medications prior to Camp starting.

When completing the medication section, please ensure every section has the following information so each order is complete. If a medication order is incomplete or there are discrepancies within the order, the Camp Harkness nurse will not administer the medication or treatment and we have the right to send the camper home until the order has been clarified. Examples of how the orders should be filled in:

Medication: Whatever the name of the medication is listed as on the Doctor's order (generic or brand)

- Ex: Lipitor, Actos, Lisinopril, Proctosol, Fleet Enema

Dose: the amount of the medication as written on the Doctor's order

- Ex: 81mcg, 25mg, 17g, 1.5%

Route: the way the medication should be administered

- Ex: by mouth, per rectum, inhaled, left eye, both eyes

Times: the amount of times a day the med should be given

- Ex: twice a day, three times a day, every other day

PLEASE NO ABBREVIATIONS

Time: the time the medication is normally given – please check the box(s) for the time of the day closest to the time normally given. It will be necessary to adjust times for some medications while at camp.

Our Medication pass times are: 8:00 a.m. 12 Noon 5:00 p.m. 8:00 p.m.

Special instructions: this refers to anything special information that pertains to the medication. For example: If a capsule needs to be opened, rinse mouth after each puff of an inhaler, give medication 30 minutes before a specific meal, etc. If the same medication is given at different times of the day, please list as a separate medication.

**Please indicate if the camper takes their medication whole, crushed, with fluids, pudding or applesauce. If not indicated, we will assume the camper will take their medication whole with fluids.

There is also a medication hold list. We ask that you please consider placing all vitamins, prescribed dental treatments, creams, lotions, or anything that can be considered 'non-essential' on hold for the duration of the campers stay with us.

We at UCP Camp Harkness thank you very much for taking the time to fill out this paperwork. We all look forward to the 2018 sessions and providing a wonderful, fun-filled camp experience.

Thank you,

UCP Camp Harkness Staff

OTHER FORMS REQUIRING MD SIGNATURE

Physical and medical information page – most of this page can be filled out by a caregiver just like the med forms, prior to going to MD.

Diagnoses and pertinent information – list all important diagnoses and any information you feel we should know re: camper medical needs.

Physical limitations – List "none" if no limitations. List use of wheelchair, walker, nonverbal, etc.

Medication allergies – List all medications that the camper is allergic to.

All other allergies – List environmental or food allergies.

Diet and fluid consistencies must be filled in even if both are regular. Please attach any diet orders or dining guidelines.

Vital statistics can be taken from the most recent Physical/MD appointment.

Chronic or recurring illness – may be left blank if no applicable.

LAST TETANUS BOOSER (TDAP) – List date of the last booster – must be within the last 10 years. If over 10 years, the camper must receive this booster with documentation provided before attending camp.

MD information – It is important to know contact information for camper's medical provider. Please list/or have MD's office list name, address, phone, fax.

MD signature and date required.

MEDICATION ADMINISTRATION INSTRUCTIONS – Just check appropriate boxes and list any helpful information to how the camper takes their medications.

PHYSICIAN'S ORDERS TO RECEIVE POTASSIUM IODINE – This form is required for attendance and requires MD signature and date.

PHYSICAL EXAM – The camper must have had a complete physical including a review of the systems done within one year of their camp session start date. The physical form in the packet has to be completely filled out, signed and dated by the medical provider. We do **not** accept the signed, dated form accompanied by an office visit printout of a physical with providers electronic signature. The printout **must** include a review of systems and be within one-year's timeframe.

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:____DOB:________Height:______Weight:________

Address:____

Diagnosis: ____Date of onset: ___________________

Past/Prospective Surgeries: ____

Medications: ____

Seizure Type: ____ Controlled? **Y N** Date of last seizure:_____

Shunt Present: **Y N** Date of last revision: ____

Special precautions, diets/needs/allergies: ____

_____May participate in all activities _____ May participate except for: ___________________________

Mobility: Independent Ambulation: **Y N** Assisted Ambulation: **Y N** Wheelchair: **Y N**

Braces/Assistive Devices:____

The participant is up-to-date on all of the following routine childhood immunizations:

Immunization	Y	N	Date	Immunization	Y	N	Date
Measles				Hepatitis B			
Rubella				Mumps			
Tetanus				Chicken Pox			
Pertussis				Other:			
Polio							
Diphtheria							
Pneumococcal Conjugate							

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

MD Name:______________________________________Address:_______________________________________

Phone: ( ) ______________________ Fax: ( )______________________________

MD Signature: ____ Date: __________

PHYSICAL EXAM

Client Name: ____

Physician: ____Date: ________________________

Vital Signs: T____ P____ R____ B/P ____ HT ____ WT ____ Ambulation Status: _____

SYSTEMS	PHYSICIAN FINDINGS
Head	
Eyes	
Ears	
Nose	
Mouth	
Throat	
Neck	
Chest	
Heart	
Abdomen	
Gastrointestinal	
Genitals	
1. Breast	
2. Testical	
3. Rectal	
Urinary	
Vaginal	
Neurological	
Musculoskeletal	
Extremities	
Mobility	
Pulses	
Lymphatic	
Skin	

Chemical Restraint: Yes ☐ No ☐ Physical Restraint: Yes ☐ No ☐

MD Signature ____ Date: ____________

High Hopes Medical Form

This form is needed if the camper wants to participate in the High Hopes Therapeutic Riding Program. Some of the information in the top portion involving medical history, immunization dates can be filled in by family and group home staff. Again, we do accept copies of an office visit printout of High Hopes with the same provisions as the camp physical, but the boxed in section of the form ***MUST*** be filled out, signed, and dated by the provider.

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide this requested information on your own medical form(s), we will accept that only when the below release section is completed, signed and dated with your form stapled to our form.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with the referral of the patient to a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

***** FOR PERSONS WITH DOWN SYNDROME:***

Neurologic symptoms of Atlanto Axial Instability : ☐ Present ☐ Not present

Name/Title: ________________________________MD DO Other:______________________

Signature: ____ Date:___________________

Address:____

Phone: ________________________________ License/UPIN Number: ___________________

CAMPER'S NAME:____

DOB: ________________________

Medication Administration Instructions

This camper takes their medications:

- ☐ Whole
- ☐ Crushed

*Please also indicate in special instructions

This camper also prefers to take their medication(s) with:

- ☐ Fluids
- ☐ In applesauce
- ☐ In pudding

Other Instructions: ____

____

____

MD Signature: ____ Date:______

Orders Valid X180 Days

Campers Name: ___________________________________ DOB: ________________

PHYSICAL AND MEDICAL INFORMATION

The following must be completed by a physician within one year of applicant attending camp

If there has been a Physical Exam within the last year, please attach copy of record when submitting camp forms – if there is no physical form or no physical exam in the last 12 months, please have the physician complete the form on the next page

Diagnoses and pertinent information:

____

____

____

____

Physical Limitations: ____

____

Medication Allergies: ____

____

All other allergies: ____

Ht: ____ Wt: ____ Temp: ____ Pulse: ____ Resp: ____ BP: ____

Diet: Regular: _____ Cut up: ½ X ½ X ½ _____ Chopped: ¼ X ¼ x ¼ _____
Moist/Ground: _____ Pureed: _____

Fluid Consistency: Regular: _____ Nectar: _____ Honey: _____ Pudding: _____

Attach Diet orders/Formal Meal Plans

Please mark any chronic or recurring illnesses:

Ear Aches: _______ Sinus: ______ Throat: ______ Stomach: ______ UTI: _______

Hypertension: _______ Cardiac: _______ Menstrual: ______ Other: _________

Safety Restraints: Yes____ No______ (Attach explanation of reason and type)

Bed Rails: Yes_____ No______ (Must have MD Signature for use)

LAST TETANUS SHOT: _________________________________

MD NAME: ____

ADDRESS: ____

PHONE: (_______)________________ **FAX**: (_______) _________________

MD Signature: ____

Date: _________________________

Orders valid x180 days

PHYSICIAN'S ORDER TO RECEIVE POTASSIUM IODIDE TABLETS

In response to the events of September 11, 2001, we have all received information of emergency preparedness from our local municipalities as well as the media.

Camp Harkness is in close proximity to the Millstone Nuclear Power Station in Waterford, CT. As a precaution, Potassium Iodide tablets have been issued to everyone who resides or works within a (10) mile radius of Millstone.

The primary care physician must sign the order below in order for the camper to attend Camp Harkness. UCP Camp Harkness will provide each camper with the Potassium Iodide Tablets if deemed necessary by State and Local Public Health Authorities.

Give one tab (130mg) of Potassium Iodide: To be used as directed by State and or Local Public Health Authorities.

Tablets may be crushed and mixed with food.

Order valid x180 days

MD Signature: ____

Date: ______________________________

CAMPER'S NAME:____ DOB: ________

MEDICATION ORDERS MUST BE COMPLETE, SIGNED, AND DATED BY PHYSICIAN

CAMPERS WILL NOT BE CHECKED INTO CAMP IF ANY INFORMATION IS INCOMPLETE AND/OR UNCLEAR

Our nursing staff will administer medication at the following intervals:

1) Morning – 8:00 a.m. 2) Noon – 12 P.M. 3) Dinner – 6:00 P.M. 4) HS – 9:00 P.M.

Complete orders must include medications, does, route, and frequency (i.e. times per day)

EXAMPLE	MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
	DEPAKOTE ER	100mg	PO	Twice Daily	X			
	Special Instructions	Take two 500 mg tablets for a total of 1000mg						

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
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Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:____ Date: ____________________

Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

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MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:____ Date: ___________________

Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

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Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:____ Date: ____________________

Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

MEDICATION ORDERS MUST BE COMPLETE, SIGNED, AND DATED BY PHYSICIAN

CAMPERS WILL NOT BE CHECKED INTO CAMP IF ANY INFORMATION IS INCOMPLETE AND/OR UNCLEAR

Our nursing staff will administer medication at the following intervals:

4) Morning – 8:00 a.m. 2) Noon – 12 P.M. 3) Dinner – 6:00 P.M. 4) HS – 9:00 P.M.

Complete orders must include medications, does, route, and frequency (i.e. times per day)

EXAMPLE	MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
	DEPAKOTE ER	100mg	PO	Twice Daily	X			
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MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

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Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:____ Date: ____________________

Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

NON-ESSENTIAL MEDICATIONS

NON-ESSENTIAL MEDICATIONS: Those medications/treatments that are to be placed on hold for the duration of camp stay and are to be restarted upon return to home.

	MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
EXAMPLE	Peridex Solution	0.12%	PO	3 times daily	X	X		X
	Special Instructions	Rinse mouth (swish & spit) after every meal with 30cc Peridex solution						

	MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
EXAMPLE	Balmex oint.	2%	Topically	2 times daily	X			X
	Special Instructions	Apply to Peri-area twice a day						

	MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
EXAMPLE	OS-Cal/MVI	1200mg	PO	Daily	X			
	Special Instructions	Take two 600mg tablets for a total of 12000mg						

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:____ Date: ____________________

Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

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MD Signature:_______________________________________ Date: ___________________
Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

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Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:_______________________________________ Date: ____________________
Orders Valid x180 Days

CAMPER'S NAME:____ DOB: ________

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MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MEDICATION	DOSE	ROUTE	TIMES	AM	NOON	DINNER	HS
Special Instructions:							

MD Signature:______________________________________ Date: ____________________

Orders Valid x180 Days

CAMPER'S NAME:____________________________ **DOB:** _________________

Camp Harkness PRN Physician's Order Sheet

Important: The following PRN orders are established to provide Medical Personnel directions to treat minor health conditions that may occur while attending camp. When PRN orders are used, the staff will document appropriately. In all cases, if symptoms persist, the camp Nurse will notify the Camp Harkness Physician or an outside Physician for further instruction.

Camp Harkness Nurses reserve the right to send any camper home at any time if displaying signs or symptoms of illness

Minor Abrasions or Laceration:

1. Cleanse area with soap and water to remove debris
2. Apply Neosporin ointment topically
3. Cover with sterile dressing/Band-Aid
4. Repeat Twice Daily x7 days

Bee Sting/Insect Bites:

1. Apply cool compress for pain and swelling
2. Observe for allergic reaction **(if s/sx of allergic reaction occur - call 911)**
3. Apply Hydrocortisone 1% cream Three Times Daily x72 hours as needed

Minor Allergy Symptoms/Allergic Reactions:

1. Signs and symptoms to include hives, itching.
2. Administer 25mg Benadryl capsule by mouth
3. May repeat above order every 4 hours x 24 hours, do not exceed 4 doses in 24 hours.
4. Observe for worsening of allergy symptoms and call 911 if needed or if respiratory distress, airway becomes involved.

____ _______________________

MD Signature Date

All Orders Valid x180 Days

Constipation:

1. Milk of Magnesia 30ml by mouth with evening med pass PRN on 3rd day if no BM
2. Dulcolax Supp. 10 mg PR PRN on 4th day if no BM
3. If no result after suppository, seek medical attention

Diarrhea (After 2nd incident of loose watery stool)

1. Clear liquids x24 to 48 hours
2. Hold stool softeners x24 hours
3. No fruit juices or fluids that are red in color
4. Monitor intake and output and encourage fluids to maintain hydration
5. Call MD if diarrhea persists; send out for medical attention if dehydration is suspected.

Elevated temperature above 101˚F:

1. Tylenol 650mg PO or PR (if not able to take by mouth) PRN every 4 Hours
2. Encourage Fluids
3. TPR Q 4 Hrs x48 Hrs
4. Report to MD if condition persists

____ ________________________

MD Signature Date

All Orders Valid x180 Days

CAMPER'S NAME:______________________________ **DOB:** __________________

C/O Headache, General Discomfort:

1. Tylenol 650mg PO or PR (if not able to take by mouth) PRN every 4 Hours
2. Not to exceed 3000mg Tylenol in 24 hours (check standing orders)
3. Observe for additional symptoms
4. Report to MD if condition persists

*** List RX Alternative __________________**

Complaints of Indigestion:

1. 2 Tbsp of Mylanta PO Q 4 Hours PRN
2. Limit to 3 doses in 24 hours
3. Report to MD if condition persists

*** List RX alternative**: __________________

Minor Rashes (less than 3"x 3" in area):

1. Apply Hydrocortisone Cream 1% topically to rash areas three times a day x72 hours PRN
2. Cover with dry sterile dressing as needed
3. Call MD if rash persists beyond 3 days or measures greater than 3"x 3"

*** List RX alternative**: __________________

Contusions:

1. Cool compress X 15 minutes
2. Administer Tylenol for discomfort per above order

Vomiting:

1. NPO x 2 hours
2. Clear liquids slowly as tolerated (Jello, ice pops, Sprite, ginger ale, etc.)
   NO RED LIQUIDS
3. No tea, coffee, or coco-cola
4. Monitor input and output
5. If condition persists notify MD; send out for medical attention if dehydration is suspected.

____ ________________________

MD Signature Date

All Orders Valid x180 Days

Menstrual Cramps:

1. Ibuprophen - 200 mg give 2 tabs PO every 6 hours PRN x48 hours while awake

*__List RX Alternative__: ______________________

General Cough, Minor – no fever:

1. Robitussin 10cc by mouth Q 4 Hours x48 hours PRN while awake

*__List RX Alternative:__ _______________________

Sunburn: (Use Sunscreen 20 and above)

1. Mild to Moderate: Cool Compress
2. Blisters: Call MD or Seek medical treatment

____ ______________________

MD Signature Date

All Orders Valid x180 Days