

CAMP SOAR MEDICAL PACKET

Attachments included in this packet:

- A. Pre-Packaged Medication Requirements and Instructions (*this page is for your records*)
 - o All pill-form medication to be administered to any camper or counselor at camp must be pre-packaged in the manner described in the "Pre-Packaged Medication Requirements and Instructions" section of this packet prior to the camper or counselor arriving to camp. You may pre-package medication yourself. **You MUST send along the original prescription bottles/containers for the nurses to use in comparing the pre-packaged pills to the prescription bottles.**
- B. Medication Authorization and Physician Approvals (*must be signed & uploaded to CampBrain*)
 - o All Camp SOAR medication authorizations (**ATTACHMENT B**), including OTC medication (**ATTACHMENT C**) must be completed with all required signatures, including signature by the prescribing physician, and returned to Camp SOAR by **June 1st, 2024**. If we do not receive these authorizations with the required signatures by this deadline, the camper/counselor's application will be moved to the waitlist.

Information to be uploaded in CampBrain:

- C. Personal Medical and Health Information Documents, including information about required physicals, immunization records, and forms to provide insurance information and health and medical history information.
 - o All campers and counselors must upload their full immunization records, health insurance cards, in addition to proof of their COVID-19 vaccination to CampBrain **by June 1st, 2024**.

Additional Information on ATTACHMENT B: Camp SOAR Medication Authorization

The attached **Camp SOAR Medication Authorization** must be completed for each camper and counselor requiring medication while at camp; **one page PER medication**.

Required Signatures: For all campers and counselors, the completed Camp SOAR Medication Authorization must be signed and dated by the camper/counselor's prescribing physician. In addition, the completed CAMP SOAR Medication Authorization for any camper or counselor under the age of 18 must also be signed by the camper/counselor's parent/legal guardian.

Instructions:

1. Complete the chart by printing it out and filling in relevant information; one page per medication
2. Submit the authorization forms to the camper/counselor's prescribing physician for approval and signature.
3. If the camper/counselor is under the age of 18, have the chart signed by the camper/counselor's parent/guardian.
4. Once all of your authorization forms are signed, upload in 1 file to CampBrain; *there is only one box to attach the medical forms so please merge all pages into 1 document before uploading.*

IMPORTANT: Missing or incomplete forms for campers may result in the camper or counselor being moved to the waitlist for Camp SOAR

ATTACHMENT A

Pre-Packaged Medication Requirements and Instructions

Camp SOAR requires all medication (including over-the-counter medication) to be **labeled & packaged** in accordance with the requirements and instructions provide below. **Starting in 2024, you must also send the original prescription bottle from the pharmacy/doctor along with the pre-packaged medication.**

- **Pill-form** medication must be pre-packaged and labeled by time and date in individual ziploc bags.
 - For campers and counselors under the age of 18, their parent or legal guardian is responsible for the packaging and labeling. Counselors who are aged 18 or over may package and label their own pill-form medication.
 - **Place all pill-form medication scheduled to be administered at camp for a single dosage time and day in a zip-closure plastic "snack size" bag and label the bag with the following information:**
 1. Camper/Counselor first & last name
 2. Name of each medication enclosed in the bag
 3. Dosage/amount given for each medication enclosed in the bag
 4. Time and Date the medication in the bag is to be administered
 - For each medication enclosed in the bag, include **ONLY** the amount of the medication needed for the day and time specified in the ziploc.
 - **You MUST send in the original prescription bottle, and it is advised to leave 2-3 extra pills in those containers in case anything happens to the pre-packaged pills at camp.**
 - What is written on the bags must match the medication chart. Here are some examples:

| |
|-------------------|
| Susie Counselor |
| Monday 8:00 AM |
| 1 Solodyn (65 mg) |
| 1 Advair (100/50) |

| |
|--------------------------|
| Susie Counselor |
| Tuesday 8:00 PM |
| 1 pill Vitamin D3 1000iu |
| |

- All **non-pill-form medication** (e.g., liquid/powder, gummies, supplements, etc.) **must be packaged in the original manufacturer or pharmacy-used packaging** (e.g., bottle) and be **labeled with the first and last name of the camper/counselor and directions for administering**.
- All **specialty supplies** such as syringes and special foods (e.g., applesauce, frosting, yogurt, etc.) that are needed to administer medication must be supplied by the parents and labeled.

With the exception of inhalers & epi-pens used by counselors, all medications brought to camp will be stored with the nursing team. Counselors may keep their inhalers on their person at all times.

IMPORTANT: All medications brought to camp MUST match the medication authorization signed by a physician. This applies to both Campers & Counselors.

How much medication should you pack?

Counselors arrive Saturday afternoon and leave Friday morning. If you are a counselor or a parent/legal guardian packing medication for a counselor under the age of 18, please provide appropriately packaged and labeled medication for 6 evenings & 6 mornings total, with any additional afternoon/lunch time medications.

Campers arrive Sunday afternoon and leave Friday morning. Parents/legal guardians packing medication for campers must provide appropriately packaged and labeled medication for 5 evenings & 5 mornings total, with any additional afternoon/lunch time medications.

ATTACHMENT B
Camp SOAR Medication Authorization 2024

INSTRUCTIONS: Please complete 1 form for each daily prescription medication, herbal supplements, vitamins, over-the-counter medications, inhalers, epi-pens, etc. For example, if your child takes 3 medications, you will turn in 3 authorization forms.

Circle One: CAMPER COUNSELOR

Participant Name: _____ **Birthdate:** _____

Primary & Secondary Diagnoses: _____

Allergies: _____

Name of Medication _____

Dosage _____

Route of Administration _____

Frequency and Time of Administration _____

Diagnosis Requiring Medication _____

Intended Effects of Medication _____

Side Effects of Medication _____

Other Medications Camper is Receiving _____

REQUIRED APPROVALS AND SIGNATURES FOR CAMP SOAR MEDICATION CHART. By signing below, each signatory acknowledges and agrees that they have reviewed the medications, dosage, route, and timing of administration provided in the chart above and approve the administration of the listed medications in accordance with the information in the chart.

FOR ALL CAMPERS AND COUNSELORS:

Physician Signature: _____

Physician Name (Print): _____

Date: _____

REQUIRED FOR ALL CAMPERS AND COUNSELORS UNDER THE AGE OF 18

I hereby request and grant permission for CAMP SOAR nurse to administer the above medication(s) to my child according to the above instructions. I further irrevocably waive and release any claims against Camp SOAR in connection with such medication. Medication will be provided by parent, per instructions above. I hereby give permission for camp personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (Print): _____

Date: _____

REQUIRED FOR COUNSELORS AGED 18 AND OVER

Counselor Signature: _____

Counselor Name (Print): _____

Date: _____

ATTACHMENT C

Camp SOAR Over-the-Counter Medication Approval and Consent for Medication Administration

Participant Name: _____ **Birthdate:** _____

Circle One: CAMPER COUNSELOR

IMPORTANT: *Medication cannot be given unless this form is completed in its entirety and signed by the licensed prescriber and parent/guardian (for counselors under 18).*

Instructions: Please print this form, complete it, and have the camper/counselor's physician sign it. Camp SOAR's Health Services stocks the following over-the-counter medications. Please check the box for all medications that you permit us to dispense to your camper or counselor. (Check all that apply.)

- Ibuprofen (Advil) 200 mg, 1-2 tabs, every 6 hours, as needed
- Ibuprofen (Advil) liquid. Designate dose _____ every 6 hours, as needed
- Acetaminophen (Tylenol) 325 mg, 1-2 tabs, every 4-6 hours, as needed
- Acetaminophen liquid. Designate dose _____ every 4-6 hours, as needed
- Acetaminophen Extra Strength (Tylenol Extra Strength) 500 mg, 1-2 tabs, every 6 hours, as needed
- Diphenhydramine (Benadryl) 25 mg, 1-2 tabs, every 4-6 hours, as needed
- Diphenhydramine (Benadryl) liquid. Designate dose _____ every 4-6 hours, as needed
- Constipation Relief (please write in name and dosage) _____

Physician Information & Approval (Required for all medication administered at Camp SOAR):

Physician Name (Print): _____ Phone: _____

Address: _____

Physician Signature: _____

Date: _____

REQUIRED SIGNATURES & AGREEMENT

I hereby request and grant permission for CAMP SOAR nurse to administer the above medication(s) to my child according to the above instructions. I further irrevocably waive and release any claims against Camp SOAR in connection with such medication. I hereby give permission for camp personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (Print): _____

Date: _____

REQUIRED FOR COUNSELORS AGED 18 AND OVER

Counselor Signature: _____

Counselor Name (Print): _____

Date: _____