

Dear Parents of Allergic Campers,

If your child has been diagnosed with allergies to food or insect stings and is under the care of a physician for this condition, please see the attached document in preparation for your child's summer camp session.

The attached documents will need to be completed by your child's physician and returned to the Camp Health Director for review prior to the start of camp. If fast acting medications to treat immediate allergic reactions (such as an Epi-Pen and/or Antihistamine ie: Benadryl) have been prescribed, you will need to provide this medication for your child while at camp.

Medications must:

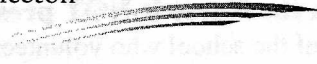
- Be labeled with child's name
- Be in the original container
- Be exactly as prescribed by the physician
- Be within medication expiration date
- If an Epinephrine Auto-Injector has been prescribed, please be prepared to send your child with (2) pens. One Epi-Pen will stay with the child's counselor and one with the Camp Health Director.

Upon receipt of your child's medical forms and Physician Completed Allergic Reaction Plan, you will be contacted by the Camp Health Director to discuss your child's healthcare needs while at camp.

For further assistance, please contact [summercamp@princetonwaldorf.org](mailto:summercamp@princetonwaldorf.org).

Thank you,

Camp Health Director



**MEDICATION FORM FOR LIFE THREATENING ALLERGIC REACTION**

This form must be completed and signed by the student's physician/health care provider and signed by the parent/guardian.

Student Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Grade \_\_\_\_\_

**SECTION 1-TO BE COMPLETED BY THE PHYSICIAN/HEALTHCARE PROVIDER**

Allergen(s) \_\_\_\_\_

Symptoms in past \_\_\_\_\_

Epinephrine required in past? Yes or NO (Circle one)

Is this a potentially life-threatening allergic reaction? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is this student asthmatic (HIGHER RISK FOR SEVERE REACTION) \_\_\_\_\_ Yes \_\_\_\_\_ No

Has allergy testing been recommended? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has allergy testing been completed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has allergy desensitization for venom reaction been recommended? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has allergy desensitization been completed? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does student require seating at an allergen-free table in the class room? \_\_\_\_\_ Yes \_\_\_\_\_ No

**A. Treatment When the Nurse is Present**

**Symptoms:**

**Give checked medication**

- If a food has been ingested (or student stung by insect, if Order is for insect sting allergy) **but no symptoms:**
- Mouth (itching, tingling or swelling of lips, tongue, mouth)
- Skin(hives, itchy rash, swelling of face or extremities)
- Gut (nausea, abdominal cramps, vomiting, diarrhea)
- Throat (tightening of throat, hoarseness, hacking cough)
- Lung (shortness of breath, repetitive coughing, wheezing)
- Heart (thready pulse, low BP, fainting, pale, cyanosis)
- If reaction is progressing (several of the above areas affective)
- Other \_\_\_\_\_

_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine
_____ Epinephrine	_____ Antihistamine

**Dosage:**

**Epinephrine:** inject intramuscularly (circle one) EpiPen      EpiPen JR.      Twinject 0.3mg      Twinject 0.15mg

**Epinephrine** may be repeated, if necessary, in \_\_\_\_\_ minutes.

**Antihistamine:** give (medication, dose, route)

**Other:** give (medication, dose, route)

**(COMPLETE BOTH SIDES)**

**B. Treatment by Delegate When the Nurse is NOT present-** NJ PL2007 c 57 directs that the school nurse shall designate additional employees of the school who volunteer to administer epinephrine to a pupil for anaphylaxis when the nurse is not physically present at the scene. **(1 OR 2 MUST BE COMPLETED)**

1.        **Delegate Order-** for suspected exposure to allergen(s) listed above and showing signs of an allergic reaction, delegates are to immediately administer epinephrine (circle one):

EpiPen      EpiPen Jr      Twinject 0.3mg (only first dose)      Twinject 0.15mg (only first dose)

**Note; Delegate may only give first dose of Epinephrine the 911 will be called immediately.**

2.        **This student's order should not be delegated.**

**B. Treatment by student (Self-Administration)** - NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction, provided proper procedures are followed.

**May student self-administer the medication prescribed (epinephrine and antihistamine)?**       \*Yes       No  
(\*If yes, please complete the questions below. In order to have permission to self-administer, all question in Step 1C must be checked "yes".)

      Yes       No Student understands the purpose, proper technique of administration and frequency of use of the medication prescribed and is capable of self-administration of the medication.

      Yes       No Student is aware that he/she must immediately report to the school nurse or teacher if he/she has a suspected exposure to allergen, any signs of allergic reaction, or has used medication.

### **Emergency Calls**

- **Call 911 and state that a student has an allergic/anaphylactic reaction and request that paramedics transport the student to the hospital.**

- **Contact the parent/guardian.**

If a student should suffer an anaphylactic reaction and neither the school nurse, nor the delegate is available, emergency medical system (911) will be activated.

**Physician/Healthcare Provider's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

\_\_\_\_\_  
OFFICE STAMP

**(END OF PHYSICIAN/HEALTHCARE PROVIDER SECTION)**

## SECTION II- TO E COMPLETED BY THE PARENTS/GUARDIAN

### A. Parent Authorization (to be completed for all students)

I hereby give permission for my child to receive medication at school as prescribed above by their physician/healthcare provider. I also give permission for the release and exchange of information between the school nurse and my child's physician/healthcare provider concerning any health matters and medications. In addition, I understand that this information will be shared with school staff on a need-to-know basis.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### B. Parent authorization for the administration of epinephrine by designees/delegates (to be completed for all students for whom the physician/healthcare provider has completed Section 1B for epinephrine delegates.)

I give consent for the administration of epinephrine via a pre-filled auto-injector mechanism by the school delegates/designees trained by the school nurse to administer epinephrine in the event the school nurse is not present at the scene. I understand that neither The Waldorf School nor any of its employees shall be liable for any injury resulting from the administration of epinephrine to a student and I agree to indemnify and hold harmless the Waldorf School and its agents against any related claims.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### C. Parent Authorization (for students with physician permission to self-administer medication)

1. I understand that neither The Waldorf School nor any of its employees shall be liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless The Waldorf School and its agents against any related claims.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

I give permission for my child to self-administer medication as prescribed on this form for the current school year as I consider him/her to be responsible and capable of self-administration of medication. Medication must be kept in its original prescription container. I understand my child is to keep the medication for self-administration with him/her at all times. For an antihistamine prescribed to be given along with epinephrine for anaphylaxis, a **single pre-measured dose for antihistamine**, in its original labeled container, is to be kept with the student, along with the epinephrine, at all times.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone # \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Phone # \_\_\_\_\_

### Emergency Contacts

1. \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_