The Arc Eastern Connecticut

Camp Harkness Packet

Summer 2019

Packet Checklist

Form	Page #	Date Due	Date Sent In	Special Instructions
Skills Checklist & Behavior Checklist	(online)	Must be submitted with application		
Supporting Documents from DDS Individual Plan (agency-supported individuals) ***These forms should be copied from the camper's DDS Individual Plan*** ♦ **DDS Emergency Fact Sheet** ♦ **IP.7 Provider Qualifications and Training Form** ♦ **Guidelines listed on IP.7 (submit copies of ALL protocols listed on IP.7: dining, mobility, safety, etc.)** ♦ **Fall Risk Screen Form** ♦ **Behavior Support Plan**	N/A	May 1, 2019		*DDS documents we will need:* 1. DDS Emergency Fact Sheet 2. IP.7 (Additional or Specific Qualification(s) Specialized Expertise and/or Training). This section is intended to alert the team of the trainings staff members need to possess when working with an individual. 3. Guidelines listed on IP.7 (submit copies of ALL protocols listed on IP.7: dining, mobility, safety, etc.) 4. Fall Risk Screen Form (from Nursing Protocol NP 11-1, Attachment A and D.) 5. Behavior Support Plan
Emergency Contact Sheet	6	June 15, 2019		
Camp Harkness Authorization Form	7	June 15, 2019		*Must be signed by Legal Guardian*
Water Safety Skill Assessment	8	June 15, 2019		*Complete and send as soon as possible*
Camp Harkness Medical Form	A-B	June 15, 2019		*Must be signed by physician*
Medication Order Sheet	C	June 15, 2019		*Must be signed by physician*
Physician's Standing Order Sheet	D	June 15, 2019		*Must be signed by physician*

Packet Contents

Registration Procedure & Timeline

TIPS:

- We recommend that you make a copy of **ALL** forms for your records.
- It is suggested to complete paperwork and submit to The Arc in stages, rather than wait for all pages to be completed.
- Please bring your copies with you on registration day to ensure an easy admission to camp.

Step	Date Due	Date Completed	Action
1	**May 1, 2019**		Send the following forms to The Arc—

All Campers:	**Agency Supported & Community Companion Home Campers:**
✓ ***Water Skills Safety Assessment*** (p. 15)	**Supporting Documents from DDS Individual Plan** ***These forms should be copied from the camper's DDS Individual Plan*** ✓ DDS Emergency Fact Sheet ✓ IP.7 Provider Qualifications and Training Form ✓ Guidelines listed on IP.7 (submit copies of ALL protocols listed on IP.7: dining, mobility, safety, etc.) ✓ Fall Risk Screen Form ✓ Behavior Support Plan

Step	Date Due	Date Completed	Action
2	**June 15, 2019**		Complete & Submit Medical Forms (pp. 8—14)

- ✓ Each camper is required to submit an updated physical annually.
- ✓ The ***Camp Harkness Medical Form*** (p. 9) must be signed by a **CONNECTICUT PHYSICIAN** within one year of attending camp.
- ✓ These forms **MUST** be submitted to The Arc by **June 15, 2019.**

Step	Date Due	Date Completed	Action
3	**June 15, 2019**		Complete Packet Information

- ✓ Please carefully review and complete the remainder of the forms in your packet and send as soon as possible. Note the special instructions listed on the Table of Contents. The remainder of Packet Information **MUST** be submitted to The Arc by **June 15, 2019.**

Step	Date Due	Date Completed	Action
4	**Prior to Arrival**		Pay Full Payment Balance

- ✓ Please make full payment made out to ***The Arc Eastern Connecticut.*** Campers ***will not be admitted*** unless full payment has been made prior to their arrival. Submit all Forms and Payment to:

The Arc Eastern Connecticut
Attn: Beryl Fishbone
125 Sachem Street
Norwich, CT 06360

Preferred method of contact is EMAIL: **bfishbone@thearcnlc.org**
Tel: (860) 889-4435 x123 **Fax:** (888) 521-7458

A prompt turnaround of these forms and payment of balance will reduce delays on registration day.
Failure to submit forms may affect the camper's stay at camp.

PLEASE READ REVERSE SIDE (P. 4)

Arrival & Departure Times:

Camper Arrival Time: **Sundays, staggered Check-In begins at 1:30 pm**

NO ONE IS ALLOWED TO UNLOAD OR PARK IN THE CABIN AREA UNTIL 2:00 PM. Campers who arrive early will be asked to visit the beach or other surrounding areas. Please cooperate and allow the staff to finish preparations prior to arrival.

Camper Departure Time: **Fridays, 12:00 pm**

No Medications will be administered after 11:30 am. It is crucial that campers are picked up BEFORE 12:00 pm, as no meals will be provided after lunch. Failure to pick up campers on time will result in additional charges.

Check-In:

Registration will take place in the stone building located in the yellow cabin area. Consult the enclosed map and signs within the park for accurate directions. **ALL PROVIDERS** must first register with the Camp Administrator. In addition, all providers dropping off medication **MUST** meet with the camp nursing staff.

Discharge & Refunds:

Camper Director reserves the right to discharge campers at any time.

Refund Policy: No refund of camp fees will be made in connection with the following circumstances: failure to attend scheduled session, late cancellations (refundable cancellations must be made at least one week prior to the start of the camper's session), late arrivals, early withdrawals, or dismissal due to misconduct. If a camper is scheduled for two weeks, he/she will not be refunded for the second week if they are sent home for misconduct or homesickness.

An exception to this policy may be made for campers who are unable to attend due to physical illness or injury. The camper must produce documentation from a physician or nurse certifying that he or she is unable to participate in camp activities. Campers who arrive late or leave early due to injury or illness will receive pro-rata refunds only. Homesickness is not considered as a basis for a refund.

Camp Information:

While campers are at camp **(beginning June 30, 2019)** you should address letters to:

Camp Harkness-The Arc New London County
301 Great Neck Rd
Waterford, CT 06385

Camp Tel: (860) 437-0636
Camp Fax: (888) 521-7458
Camp Administrator: Kathleen Cote

Preferred method of contact is EMAIL: **kcote@thearcnlc.org**

Note: The camp office phone will not be set up until June 28, 2019. Until that time contact Beryl Fishbone at bfishbone@thearcnlc.org (*Preferred*) or (860)889-4435 x123.

Schedule & General Information

Please review the following schedule carefully.
Refer to your confirmation letter for assigned session(s).

2019 Camp Session Dates	
Session #	**Dates**
Session **1** (*One Week*) *(Adults over 30)*	**Begins:** Sunday, June 30- **Staggered Check-In begins at 1:30 pm** **Ends:** Friday, July 5— **12:00 pm**
Session **2** *(One Week)* *(Adults over 30)*	**Begins:** Sunday, July 7 - **Staggered Check-In begins at 1:30 pm** **Ends:** Friday July 12 — **12:00 pm**
Session **3** *(One Week)* *(Adults over 30)*	**Begins:** Sunday, July 14- **Staggered Check-In begins at 1:30 pm** **Ends:** Friday, July 19 — **12:00 pm**
Session **4** *(One Week)*	**Begins:** Sunday, July 21 - **Staggered Check-In begins at 1:30 pm** **Ends:** Friday, July 26 — **12:00 pm**
Session **5** *(One Week)* **YOUNG ADULT** ages 18-30	**Begins:** Sunday, July 28 - **Staggered Check-In begins at 1:30 pm** **Ends:** Friday, August 2 — **12:00 pm**
Session **6** *(One Week)*	**Begins:** Sunday, August 4- **Staggered Check-In begins at 1:30pm** **Ends:** Friday, August 9 — **12:00 pm**

Camper Name: _____

Please make sure to list TWO SEPARATE contacts and phone numbers.

Do not list only office or work numbers.

There should be a specific person AND numbers to reach this person 24 hours a day!

Contact #1

Name of Contact	
Relation to Camper	
Phone #1	
Phone #2	
Cell Phone	
Other	

Contact #2

Name of Contact	
Relation to Camper	
Phone #1	
Phone #2	
Cell Phone	
Other	

Comments: _____

Please make sure the contact person understands they are responsible to respond to medical and behavioral issues throughout the camper's stay.

Camper Name: _____ **Guardian:** _____

Camp Harkness Authorizations Form

Authorization for Medication Administration, Medical, Surgical or Dental Treatment

I request that medication be administered to the above listed camper as described on the Medical forms submitted to the Camp Nursing Staff. I hereby give permission to the Director and/or Medical Personnel of The Arc Eastern Connecticut to authorize emergency medical, surgical, or dental treatment, for the applicant including administration of medications, immunizations, and anesthesia	INITIALS:	

Activities Consent

I give permission for applicant to participate in all planned activities of the agency.	INITIALS:	

Photo/Image Release

I give permission to the agency to photograph or video the applicant. I understand that the images may be used for educational purposes, agency publications and/or postings on the agency web site. In addition, images may be also be used for the public information through the news media.	INITIALS:	

Please Note: A photo will be taken and kept on file of **all campers** for identification purposes.

Release of Medical Information

I give permission to the agency to access all medical information relevant to the applicant's health and safety during his or her stay at camp. This includes information on the attached medical forms as well as phone conversations and/or correspondence subsequent to registration. All information will be kept confidential and will be used for legitimate purposes by our medical staff only.	INITIALS:	

Please note: The Arc Eastern Connecticut is subject to the regulations set forth in the Health Insurance Portability and Accountability Act (HIPPA). You are entitled to review a copy of our Notice of Privacy Practices. If you wish to do so, please contact our Privacy Officer at 860-889-4435.

Authorization to Administer the KI tablet in the Event of a Radiological Incident.

Potassium Iodide (KI) is the counter drug that helps to protect the thyroid from absorbing radioactive iodine. The State of Connecticut has recommended the use of Potassium Iodide tablets when directed by local or State Public Health authorities in the event of a radiological incident at the Millstone Power Station. Camp Harkness is within the 10 mile radius of the Millstone Power Station. Please refer to the website **ct.gov/demhs** which has been prepared by the State of Connecticut Department of Public Health for information about the contraindications and potential side effects of taking the KI tablet. Link to info: http://www.ct.gov/demhs/lib/demhs/rept/dph_ki_public_fact_sheet_english_07.pdf

I have read and understood the State of Connecticut Department of Health information at the above link about the contraindications and the potential side effects of taking the KI tablet. I understand that it is my responsibility to notify the camp staff in writing if I desire to change my authorization as indicated below. Please indicate your **authorization** or **refusal** by checking the appropriate box below:

☐ YES, I want the above named camper to be administered the KI tablet when: • The Governor declares a nuclear emergency, AND • Individuals in a specified area, which includes Camp Harkness, are advised by the Emergency Alert System (EAS) to take the KI tablet. • I understand that the ingestion of the KI tablet under these circumstances is voluntary	☐ NO, I do **NOT** want the above named camper to be given the KI tablet in the event of a nuclear emergency.

X	
Signature of applicant, parent, or legal guardian	*Date*

Water Safety Skill Assessment

State of Connecticut
Department of Developmental Services
Individual Plan and Individual Short Plan Addendum
IP Addendum: Aquatic Activity Screening

The Arc Eastern Connecticut
Camp Harkness

Name:	*DDS#:*	*Date:*

This screening is in effect for one year from the date on this form as part of the IP or up to three years for individuals with an IP Short Form. Request for any changes or updates to this form must be made through the team process.

SECTION 1: Screening For Presence and Participation in Aquatic Activities

Definitions:

Aquatic Activities: *are all water related activities including swimming, boating, fishing, hot tubs, water parks and those activities PROXIMAL TO WATER.*

Proximal to Water: *aquatic activities are those at any location where there are bodies of water present at the intended destination that are open and accessible to individuals. This means there are no barriers to prevent access such as secure fencing or padlocked gates. Contact with the water may, or may not be intended. Bodies of water include, but are not limited to: streams, creeks, oceans, lakes, ponds, pools, hot tubs, wading pools, natural or man-made water areas or similar. Proximal to water activities include, but are not limited to: picnics in a park where there is water, feeding the ducks at a pond, unrestricted access to backyard wading (or swimming) pools or hot tubs, walks on the beach or similar.*

Shallow Water: *is defined as water at or below the height of the individual's chest.*

Deep Water: *is defined as water above the height of the individual's chest.*

The Planning and Support Team should assign an Aquatic Activity Code "0 to 6" for the individual

Aquatic Activity Code- *CHOOSE ONE:

- ☐ **0 = Does NOT** swim or participate in **ANY** aquatic activities. **If coded as "0", Section 2 should have "NO" circled for all activities listed.**
- ☐ **1 = Proximal to Water Activities Only – Must Be With Staff.** Participates only in activities proximal to water as defined above.
- ☐ **2 = Shallow Water Only**; limited or no swimming skills. **Does Not Respond** to verbal redirection; may not recognize dangerous situations.
- ☐ **3 = Shallow Water Only**; limited or no swimming skills. **Usually Responds** to verbal redirection; may/may not recognize dangerous situations.
- ☐ **4 = Deep Water** swimmer; can swim in deep water **with supervising staff**; may have medical or safety needs
- ☐ **5 = Independent Deep Water Swimmer;** may go swimming without staff; ***AND/OR*** **independently accesses aquatic activities without staff;** may not, or chooses not, to swim. The Water Safety Checklist shall be reviewed annually with the individual to encourage safe aquatic activity participation.
- ☐ **6 = Aquatic Activity Level Not Known.** Approved only for aquatic activities as permitted below and MUST BE IN A ONE-TO-ONE enhanced individual to staff ratio at all of these activities until code is determined and approved.

SECTION 2: Aquatic Activities and Supervision Needs – Include Staff to Individual Ratio as Appropriate

NOTE: If supervision needs are unknown due to lack of previous participation, the individual must be in a 1:1 enhanced staff to individual ratio at all aquatic activities they are able to participate in, until a safe appropriate ratio can be determined and approved.

AQUATIC ACTIVITY	*ABLE TO* **PARTICIPATE?** *(CIRCLE ONE)*	*INDIVIDUAL SUPERVISION NEEDS* *STAFF: INDIVIDUAL* *(CIRCLE ONE)*	*COMMENTS* *(NEEDS LIFEJACKET, MEDICAL INFORMATION, ETC.)*
Activities Proximal to Water	**YES NO**	***1:3 or 1:2 or 1:1***	
Boating	**YES NO**	***1:3 or 1:2 or 1:1***	*LIFEJACKET MANDATORY FOR ALL.*
Swimming	**YES NO**	***1:3 or 1:2 or 1:1***	
Able to access aquatic activities independent of staff supervision	**YES NO**	*IF 'YES' IS CHECKED, THE INDIVIDUAL MAY ONLY HAVE AN AQUATIC ACTIVITY CODE OF '5'*	*IF 'YES' IS CHECKED, WATER SAFETY CHECKLIST HAS TO BE REVIEWED WITH THE INDIVIDUAL BY STAFF EVERY YEAR BETWEEN MARCH 1ST & MAY 1ST*

_____ _____ _____

Signature *Date* *Relationship to Camper*

Please be aware that it is warm during the day and cool at night.
Clothing for BOTH temperatures is needed at camp.

The following is a list of clothing and other items which we recommend sending with the camper for their 5 day stay:

- ✓ Shirts & Sweatshirts
- ✓ Shorts & Pants
- ✓ Undergarments
- ✓ Pajamas
- ✓ Bathrobe
- ✓ Comfortable Shoes (2 pairs)
- ✓ Socks
- ✓ Coat
- ✓ Laundry Bag
- ✓ Bath & Beach Towels
- ✓ Swimsuit
- ✓ **Two Sets of Sheets, Pillow, Blankets *(Big Comforter Recommended…not sleeping bag)***
- ✓ **Toiletries** (toothbrush, toothpaste, hairbrush, shaving needs, shampoo, hair dryer, etc.)
- ✓ Sanitary Products
- ✓ Sun block
- ✓ Bug Spray
- ✓ Raincoat

Laundry services are limited at camp.
Campers should come with enough clothing to last throughout their ENTIRE stay at camp.

Special Notice Re: Bedding & Clothing:

1. Please be sure to pack enough clothes and bedding for the entire stay.
2. ***We cannot be responsible for items lost or forgotten***. Please mark items with the camper's name or initials.

Special Notice Re: Medication:

It is vital that the following instructions be followed regarding medication.
Failure to do so may result in the camper being sent home:

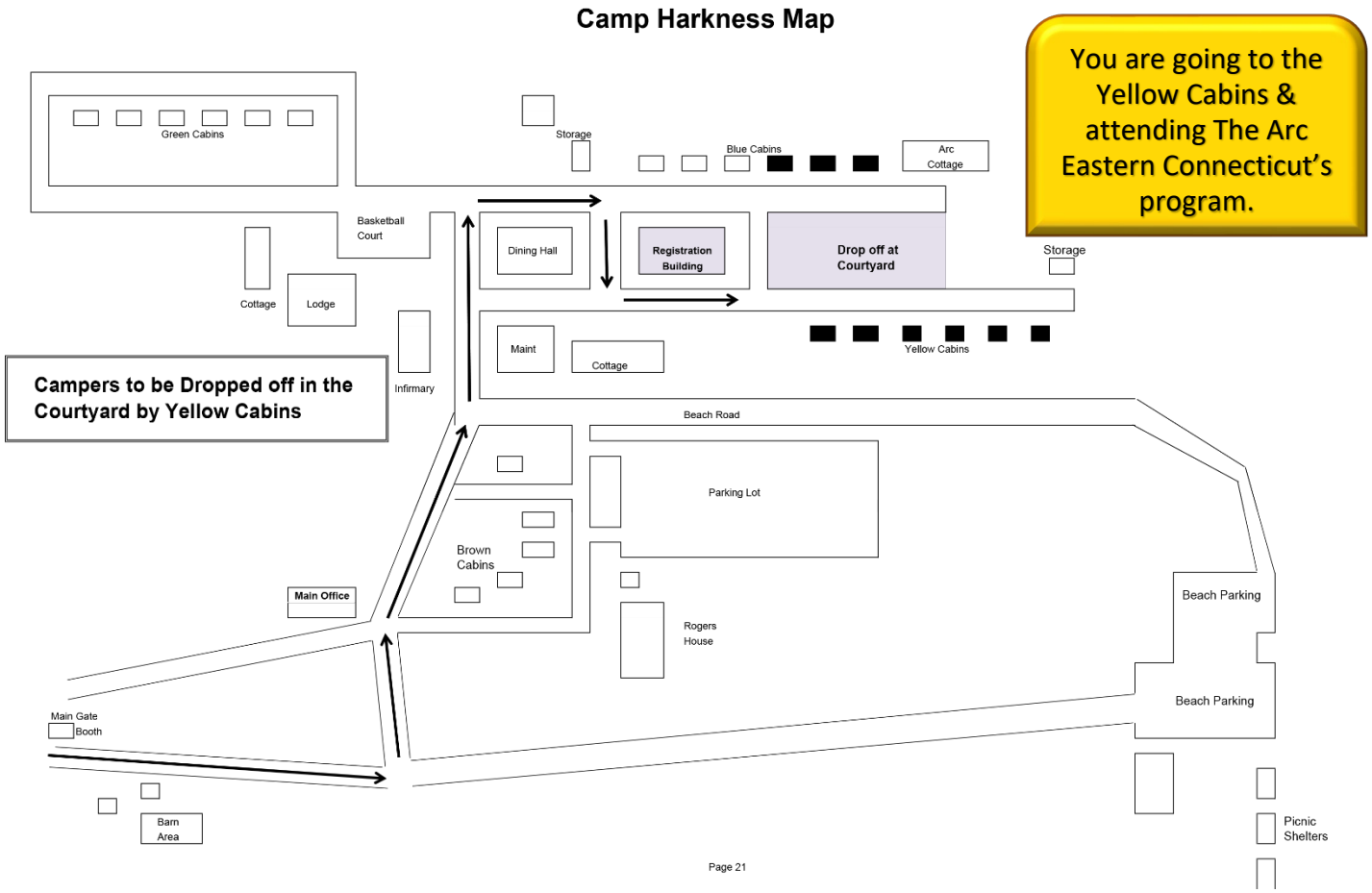
1) **All Medication** sent with the camper **must match written orders signed by a physician.** This must be listed on the Medication Order Sheet provided in this packet.
2) It is imperative that enough medication is sent to last the camper's entire stay.
3) Medication must be in the original drug store bottles with labels attached or in blister packs.
   Pill boxes will not be accepted.
4) Medications must be identical to those listed on the Medication Order Sheet you submit in advance. **If there are medication changes** which occur subsequent to your submission of the Medication Order Sheet, **an updated Written Order signed by a physician must accompany the medication**.

The Arc at Camp Harkness, 301 Great Neck Road, Waterford, CT 06385

From Interstate 395 S:
Take Exit 2 for Route 85 south. Turn left at end of exit ramp onto Route 85 South. Turn right onto Cross Rd. Follow Cross Rd to the end and turn left onto Route. 1. Proceed east (toward Waterford/New London) on Route 1 for 1.6 miles to a stop light. Take a right onto Avery Lane (Silva's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Route 213 (Great Neck Rd). Proceed on Route 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.

From Interstate 95 N:
Take exit 75 onto Route 1. Proceed east (toward Waterford/New London) on Route 1 for 3.8 miles to a stop light. Take a right onto Avery Lane (Silva's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Route 213 (Great Neck Rd). Proceed on Route 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.

From Interstate 95 S:
Take exit 81 (Cross Rd.) At the end of the exit ramp, turn left. Follow to traffic light. Turn left onto Cross Rd. Follow Cross Rd to the end and turn left onto Route. 1. Proceed east (toward Waterford/New London) on Route 1 for 1.6 miles to a stop light. Take a right onto Avery Lane (Silva's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Route 213 (Great Neck Rd). Proceed on Route 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.



Important: ***Please review the following information carefully. Failure to comply with any one of these standards could result in your camper being sent home.***

1) Please allow **Physician** to complete the physical examination section **AND** list of medications. If this section is left incomplete, the form will be returned.
2) A completed Camp Harkness Medical Form with a **Connecticut** doctor's signature is required within one year of attendance at camp.
3) Diagnosis and pertinent medical information must be listed.
4) Must have tetanus booster within last ten years.
5) Authorizations for medical, surgical and dental treatments must be signed.
6) **All medications must have written orders signed by a physician**. When changes are made after medical forms are completed and sent, **an updated written order** signed by a physician must be sent to The Arc Eastern Connecticut **prior** to camp attendance.
7) Medication must be in the **original containers** from the pharmacy with **proper labels**. **Do not put medication in individual envelopes or pill boxes**, even if the camper self-medicates.
8) **Sufficient medication and supplies** are a must for the entire stay of the camper. This includes all medications, syringes, diabetic testing and personal items.
9) Medication will be administered at the following intervals:

    - AM- 8:30 am
    - Noon-12:30 pm
    - Dinner- 6:00 pm
    - Hour of Sleep- 9:00 pm
    - Insulin ½ Hour before meals. Testing as ordered.

10) The Arc Eastern Connecticut has its own records for administration of medication, narcotic sheets, etc. Please do not ask the camp nurses to sign off your home or hospital records. Copies of our forms will be provided when medication is returned on check out day.
11) All campers must give medication to the nurse to be locked in the infirmary.
12) All adaptive equipment must be provided by the camper and should be in good repair. This includes braces, wheelchairs, crutches with extra tips, technology tools, feeding utensils, etc.
13) A doctor's order is needed for mechanical restraint of the campers in wheelchairs or beds, including **bedrails.** Campers must provide own bed rail pads.
14) Communicable diseases such as athlete's foot, ringworm, "pink-eye", etc. will lead to the camper being sent home, unless a doctor's certificate accompanies the camper regarding treatment and states the camper is not contagious. **To minimize the spread of infectious diseases, any/all infected camper(s) will be sent home**.
15) We do not provide special diets other than ground or puree.
16) Camp Harkness maintains contracts for medical services with a local physician's group as well as Lawrence & Memorial Hospital in New London, CT.

In order to keep the number of medications to a minimum, please discontinue all nonessential medications (i.e. Vitamins, creams, and ointments) for the duration of the camper's stay.

Complete ALL areas. *Incomplete forms will be returned!*

Camper Name:	Sex: ☐ M ☐ F	Age:	DOB:
Camper Address:	DDS#:		SSN#:
Insurance Company:		Insurance Number:	

***Please circle which person should be called* FIRST.**

Guardian:		Telephone #:	( )
Emergency Contact 1:		Telephone #:	( )
Emergency Contact 2:		Telephone #:	( )

The remaining sections of pages A-D **MUST** be completed and signed by a **PHYSICIAN!**

Height		Weight		BP	

Diagnosis and Pertinent Information:

Allergies:

Required Adaptive Equipment: *(braces, utensils, etc.)*

Past / Prospective Surgeries:

Mobility: ☐ Independent Ambulation ☐ Assisted Ambulation ☐ Wheelchair

Shunt Present? ☐ Yes ☐ No Date of last revision: _____ / _____ / _____

Does Camper Require Bedrails? ☐ Yes ☐ No Does Camper Require Bedrail Pads? ☐ Yes ☐ No

Campers must supply own bed rail pads.

Restraints: ☐ Yes ☐ No	Specify Reason and Kind:

Physician Initials:	

Camp Harkness Medical Form (cont.)

Special Diet: ☐ Whole ☐ Chopped ☐ Ground ☐ Puree		Liquid Consistency: ☐ Thin ☐ Nectar ☐ Honey ☐ Pudding
Asthma: ☐ Yes ☐ No	Immunizations Complete: ☐ Yes ☐ No	**Date Last Tetanus:** _____ / _____ / _____
Seizures: ☐ Yes ☐ No Type: _____	Frequency: _____	Date of last seizure: _____ / _____ / _____
Diabetes: ☐ Yes ☐ No Controlled by: ☐ Diet ☐ Oral Medication ☐ Injection		***PLEASE FILL OUT DIABETIC PROTOCOL SECTION***

Diabetic Protocol

Diet Restrictions:	
Can camper have a single serving of special treats once per day during camp programs? (e.g. one s'more, small ice cream cup, small piece of birthday cake)	**☐ Yes ☐ No**
Please list any specific requirements for monitoring the camper's recreational activities:	
Glucose Testing?	**☐ Yes ☐ No**
Glucose Monitoring Schedule (please note days and frequency): _____ _____	
Notify Doctor if BS is < _____ or > _____ (Please include insulin sliding scale or oral medication adjustments on Medication Order Sheet)	
Camper's desired test range:	
Does camper use Glucagon? (Please include order on Medication Order Sheet)	**☐ Yes ☐ No**

Please indicate current or past difficulties in the following systems/areas, including surgeries:				
Auditory	☐ Yes ☐ No	Muscular	☐ Yes ☐ No	*Please comment on any items marked "Y":*
Visual	☐ Yes ☐ No	Balance	☐ Yes ☐ No	
Tactile Sensation	☐ Yes ☐ No	Orthopedic	☐ Yes ☐ No	
Speech	☐ Yes ☐ No	Allergies	☐ Yes ☐ No	
Cardiac	☐ Yes ☐ No	Learning Disability	☐ Yes ☐ No	
Circulatory	☐ Yes ☐ No	Cognitive	☐ Yes ☐ No	
Integumentary/Skin	☐ Yes ☐ No	Emotional/Psychological	☐ Yes ☐ No	
Immunity	☐ Yes ☐ No	Pain	☐ Yes ☐ No	
Pulmonary	☐ Yes ☐ No	Other:	☐ Yes ☐ No	
Neurologic	☐ Yes ☐ No			

FOR PERSONS WITH DOWN SYNDROME: Neurological symptoms of Atlantoaxial Instability ☐ Present ☐ Not Present

Camp Activities:

May Participate in all Camp Activities: ☐ Yes ☐ No List Exceptions:

Physician Initials:	

Medication Order Sheet

Must be completed and initialed by physician

Camper Name:_____

***Discontinue* all nonessential vitamins, creams, and ointments for the duration of the camper's stay.**

Special Needs Rates will be applied if TOTAL medications exceed ten.

Please complete all sections completely, including **DOSE, ROUTE** and **INTERVAL**.

#	Drug Name	Dose	Route	Interval			
				AM	Noon	Din	HS
1							
	Special Instructions:						
2							
	Special Instructions:						
3							
	Special Instructions:						
4							
	Special Instructions:						
5							
	Special Instructions:						
6							
	Special Instructions:						
7							
	Special Instructions:						
8							
	Special Instructions:						
9							
	Special Instructions:						
10							
	Special Instructions:						
			Physician Initials:				

Physician's Standing Order Sheet

The following Standing Orders are established to provide Medical Personnel directions to treat minor health conditions. When standing orders are used, the staff will document appropriately. If symptoms persist, camp nursing staff will notify camp doctors or outside physician for further instructions.

Please modify doses for campers if necessary.

Camper Name:_____ **Date last tetanus:**_____

Abrasion or Laceration
1. Clean with soap and water or wound wash saline and remove debris
2. Apply antibiotic cream topically
3. Cover with dry sterile dressing
4. Repeat until healed

Athlete's Foot
1. Antifungal cream or powder BID topically
2. Review in two (2) weeks for effectiveness

Bee Sting or Insect Bites
1. Apply cool compress for pain and swelling
2. Apply Caladryl or Calamine lotion to relieve itching
3. Benadryl 25mg PO for excessive itching
4. Administer EpiPen for anaphylaxis and call 911

Bites, Human
1. Cleanse with soap and water
2. Check tetanus status
3. Call MD or seek medical treatment

Bites, Tick
1. Remove Tick
2. Cleanse area
3. Apply antibiotic cream
4. Monitor for increased redness of area or "Bulls Eye Rash"
5. Monitor for malaise, low grade temp or muscle/joint pain

Blistex / ChapStick
1. Apply Q 4 Hrs PRN for dry, chapped or sunburned lips

Burns
1. Flush with cold water
2. Observe for blisters / infections
3. Report to physician accordingly

C/O Headache, General Discomfort
1. Tylenol 500mg or Motrin 400mg PO Q 4 Hrs PRN X 24 Hrs
2. Observe for additional symptoms
3. Report to MD if condition persists

C/O Indigestion
1. 2 Tbsp. of Mylanta PO PRN Q 4 Hrs
2. Limit to 3 doses in 24 Hrs
3. Sip Ginger Ale
4. If pain persists, seek medical treatment

Constipation
1. 6 oz. prune juice on 2nd day if no BM
2. Dulcolax supp. PRN on 3rd day if no BM
3. Fleet on 4th day if no BM
4. If no result, seek medical attention

Contusions
1. Apply ice pack X 15 minutes
2. Monitor for bruising

Cough / Cold
1. Robitussin 10 cc PO Q 4 hours. Do not exceed more than 6 doses in 24 hrs.
2. Push clear fluids
3. Observe for other symptoms (TPR)
4. If cough persists, temperature spikes or respiratory distress occurs, call MD or seek medical treatment

Diarrhea (After 2nd incident)
1. Clear liquids X 24 to 48 Hours
2. Hold stool softeners X 24 Hours
3. No fruit juices
4. Monitor intake and output
5. Imodium AD-2mg PO (per package instructions)
6. Call MD if diarrhea persists (per package instructions)

Elevated Temperature Above 101 degrees
1. Tylenol 500mg PO Q 4 Hrs PRN X 24 Hrs
2. Force fluids
3. TPR Q 4 Hrs X 48 Hrs
4. Call MD if temperature persists

Groin Rash
1. Zinc oxide to be applied PRN for groin rash topically
2. Must wash and dry well between application

Irritated Eyes
1. Artificial Tears 2 drops each eye, PRN Q 4 Hrs

Menstrual Cramps
(choose one of the listed medications below)
1. Advil 2 Tabs Q 4 Hrs PRN
2. Midol 2 Tabs Q 4 Hrs PRN
3. Pamprin 2 Tabs Q 4 Hrs PRN

List RX Alternative:

Runny Nose
1. Dimetapp Elixir * 5cc PO Q 4 Hrs PRN X 48 Hrs

List and provide RX Alternative:

Rashes (Generalized)
1. Apply cortisone cream 0.5% topically to affected area 3 times daily X 72 Hrs
2. Call MD if rash persists

Sunburn (use sunscreen SPF 15 and above)
1. Mild to Moderate: Cool Compress
2. Apply Aloe to affect areas
3. Blisters: Call MD / Seek medical treatment

Vomiting
1. NPO X 2 Hrs Then:
2. Clear liquids slowly as tolerated (Jell-O, ice pops, 7-Up, Ginger Ale, Kool Aid)
3. No Tea, Coke, or coffee
4. VS/shift X 24
5. Monitor intake and output
6. If condition persists, notify MD

Potassium Iodide (KI) Tablets

1. Use only as directed by State or Local Public Health Authorities in the event of a radiation emergency
2. Give one tab (130mg) of Potassium Iodide to adults and children over one (1) year of age. This tablet should be crushed and added to food for small children

The preceding orders will be in effect from: **June 1, 2019 to December 31, 2019** *(May be substituted for generic brands)*

Physician Name (print) MD DO Other: ____	*Physician Signature*	*Date*
Physician Address		*Telephone*