GCS SUMMER CAMP HEALTH SERVICES POLICY AND PROCEDURES 2024

General Health Care

Staff should practice and encourage campers to practice, daily health care habits such as good hygiene, dental care, proper nutritional intake and obtaining adequate sleep. An orientation by the camp nurse[1] or designee is provided to the staff to review procedures prior to the first session of camp. The orientation includes a review of Universal/Standard Precautions procedures. It will include, but is not limited to, a definition of Standard Precautions as a set of procedures designed by Centers for Disease Control and Prevention (CDC) to prevent the spread of known and unknown sources of infections. It will be emphasized that all blood and body fluids will be considered infectious. The importance of hand washing for both the camper and the staff will be highlighted and times to wash hands, such as before and after helping with snacks and lunch and any time assisting with first aid measures, will be reviewed. Use of personal protective equipment (gloves and masks) as a method to prevent infection will be taught. Other methods, such as cough etiquette, environmental cleaning and proper waste disposal of any contaminated clothing will be included in the orientation material.

GCS Summer in the Country Illness and Injury Policy

GCS Summer in the Country will adhere to the GCS Health Services Illness and Injury Policy which includes protocols for student illnesses and injuries, as well as parent/guardian communication responsibilities. This policy also includes our guidance for COVID. Please see Appendix A for the GCS Health Services Illness and Injury Policy.

Daily Health Observations

The counselors are to observe each camper's general health status as they meet with their group each morning. Any signs of illness or injuries are to be reported to the camp nurse. The camp nurse will follow up on any injuries previously noted. Health room visit logs and observations will be captured in either Summer in the Country's electronic record system, CampBrain, or by hard-copy, in lined, spiral-bound daily medical log books (Camp Health Record Log).

Health Records

Staff Records: All staff will complete the Summer Programs Staff Emergency and Health Information Forms (Appendix B).

Camper Records: All parents of campers will complete the online medical questions in CampBrain. If medications are required during the camp day this information is also entered, noting when to be administered. Camper health information includes DHMH 896 records for all campers from out of the country and those entering kindergarten or below (electronic copies are acceptable). Instructions for parents to submit required immunization records are included. In addition, GCS Summer in the Country requires tuberculosis screening for campers from high-

[1] Camp nurse or camp nurse denoted Registered Camp nurse (State of Maryland).

risk tuberculosis countries. See Appendix C for further information about the GCS Tuberculosis Screening & Testing Policy.

Note: Both staff and camper forms comply with standards for required information.

Submitted immunization forms will be kept on file in the health room. The camp nurse will review medical information and identify the presence of health concerns for each camper. Individual consideration will be given to campers with chronic health conditions, such as asthma, food allergies, and diabetes. The camp nurse may contact the parent of such campers for further assessment and evaluation. All campers should be in a stable health state. A camper with diabetes will be expected to be independent in much of his/her self-care, such as testing blood sugar, monitoring, and reporting signs and symptoms of hypoglycemia and hyperglycemia, calculating carbohydrates and administration of insulin. Supervision will be provided, if necessary.

Campers whose immunization documentation is needed and has not been submitted prior to camp will be contacted via e-mail or phone. Campers who fail to provide the needed medical documentation or health forms by the start of camp will not be permitted to attend. Campers whose medication orders are not completed properly by the parent and physician will not be accepted.

A medical concerns list will be distributed to the camp directors and head counselors at the beginning of each session. Information will be disseminated via hard copy format discreetly, maintaining all privacy and confidentiality. The medical concerns list will include but is not limited to the following conditions: Seizures, diabetes, asthma, allergies (food, environmental), ADHD, anxiety disorders, the need for medication at camp, and other illnesses/concerns as deemed appropriate by the camp nurse. Procedures for medically fragile campers will be handled on an individual basis.

Health Room Visit Documentation and the Medical Log
The medical concerns list is to be kept confidential and kept in a secure location.

Health room visit documentation is done in Summer in the County's electronic record system, CampBrain, by the camp nurse who has secure access to the software management record system.

Anyone other than the camp nurse who needs to document a health issue or health room visit will document this visit in the Camp Health Record Log. The Camp Health Record Log will be kept in each Health Room. Each entry is to include the date, name of camper, ailment, treatment provided, and initials of the person providing care. All entries are to be written in ink with no lines skipped.

Counselors who are trained in first aid may treat minor injuries and document in the log as previously outlined. First aid supplies are located with the Camp Health Record Log in all buildings. The logs will be reviewed by the camp nurse.

All injuries, illnesses, and reportable diseases as delineated in COMAR 10.06.01 are recorded in CampBrain and/or the Camp Health Record Log. At the completion of camp, the Camp Health Record Logs are kept in the health room for a period of three years. They are available for review by the Maryland Department of Health and Maryland Youth Camp.

Medications

Prescription and Over the Counter Medication will be administered following the Summer in the Country Glenelg Country School Medication Policy (Appendix D) and the appropriate form(s) - the Asthma Action Plan/Medication Authorization Form (for asthma medications like Albuterol inhalers), the Allergy Action Plan/Medication Authorization Form (for EpiPens, Auvi-Qs and/or Benadryl), and the Medication Authorization Form (for any other medications) - (Appendix E, F, and G), are completed and reviewed by a camp nurse. This applies to campers and staff members under 18 years of age.

Prescription medication must be in its original container bearing the pharmacy label which shows the camper's name, prescription number, date filled, prescribing physician's name, name of medication, direction for administration, and expiration date.

All medication will be kept in the associated health room of the building the camp is being hosted in that week. Medications are kept in a locked cabinet, except for medications that need to be refrigerated. The camp nurse is responsible for all medication on the Summer in the Country campus.

Campers requiring emergency medications such as auto-injectable epinephrine or rescue inhalers will have either an Allergy Action Plan/Medication Administration Form or an Asthma Action Plan/Medication Administration Form outlining use of such medication. These forms are designed to serve as both the physician authorization and action plan. The procedure for use of emergency inhalers for campers with respiratory conditions, such as asthma, and requiring the emergency use of a rescue inhaler will follow the Asthma Standard of Care Procedure (Appendix H).

Medication will be administered under the supervision of the camp nurse, certified medication technician, or staff member having taken the 6-hour medication administration course by Maryland State Department of Education (MSDE) or a designated counselor. If the camper is away from the day camp location (i.e., field trip), the medication will be packaged/packed, and administration will be delegated by the camp nurse.

All counselors and staff who supervise a camper requiring emergency medications, such as an inhaler or auto-injectable epinephrine, will be trained in its use and administration by the camp nurse or designee.

Daily record of medication that is administered will be recorded on the campers Medication Administration Record (Appendix I). The medication form for campers receiving medication will be kept in a notebook or with the medication. A copy of the prescription and non-prescription Physician's Desk Reference (PDR) or equivalent online drug reference resource is available in the health room.

All unused medication will be returned to the parent at the end of the camping session or on the last day of camp. A notation of the return is made on the GCS Medication Receiving/Disposing Record (Appendix J).

Non-Medications
Permission for sunscreen and insect repellent is included in the online medical registration. The parent is asked questions such as: when to apply, if supervision is required, and are instructed to apply prior to camp and to be brought to camp in a labeled Ziploc bag with the camper's name.

Health Treatment Area and Procedures for Injury and Illness Treatment
Campers and staff are treated for minor injuries and illnesses in the health room. Procedures and protocols to be followed are outlined in the GCS Health Services Policy and Procedure Manual and the Guide for Emergency Care in Maryland Schools, both of which are located in each health room on campus. The camp nurse is available on site during the hours that camp is in operation.

The health room affords temporary isolation in case of contagious diseases. It is private, quiet, and continually supervised. It is equipped with all necessary first aid supplies. A bathroom with a sink is in the health room. A telephone is in the health room.

In the case of minor injuries that occur on the campground, two first aid kits are in the (1) summer camp office and (2) at the pool/gym. Counselors trained in first aid may administer to minor injuries in these locations. The camp director/camp assistant or designee checks the first aid kits and restocks them as needed.

Reporting of Minor Injuries and Illnesses
All visits to the camp health room will be documented in CampBrain or the Camp Health Record Log. Parents of campers who are ill will be notified by phone. Campers receiving minor injuries may be notified by phone or via our GCS Summer Camp Health Room Visit Form (Appendix K).

If a camper has sustained a minor head injury, they will be evaluated in the health room. If determined they are unable to return to camp activities, their parent will receive the Health Room Visit Form that includes information on minor head injuries.

Reporting of Major Injuries and Illness (including campers presenting with life-threatening allergic symptoms of unknown allergies)
When a major injury or illness occurs, the camp nurse will contact the parent or emergency contact person immediately. The local emergency response system (911) will be activated if appropriate. The closest hospital is Howard County General Hospital. The phone number is 410-740-7777. Poison Control's phone number is 1-800-222-1222.

In the case of a life-threatening emergency, the local emergency response system will be activated. A member of the camp staff will stay with the camper or staff member until emergency medical personnel arrive.

The camp nurse and at least one other adult staff member are certified in CPR and First Aid. Emergency First Aid and CPR will be initiated if indicated. The Camp Director maintains the list of additional camp staff certified in CPR and First Aid.

If a major injury or illness occurs when away from the camp facility, 911 will be called immediately. Should an injury result in a Bloodborne Pathogen exposure the Camp Nurse must be contacted and will follow the established GCS Exposure Control Plan. The GCS Exposure Control Plan is available in each Division Building and in each Health Room on the GCS School Campus.

Contagious Diseases and Reportable Conditions

If a communicable disease is suspected, the camper or staff member will be isolated immediately. The parent or emergency contact is notified. The camper or staff member is not permitted to return to camp without a note from their health care provider indicating the person is free from contagious disease.

If a health situation arises that may affect the entire camp, the camp director and staff will be informed by the camp nurse. A written communication will be distributed to all parents the day the situation arises.

In case of an injury or illness which results in death, or which requires resuscitation or admission to a hospital, or an illness suspected by a physician of being water-born, food-born, air-borne, or vector-borne, or spread by contact, the event is reported within 24 hours to the Howard County Health Department at 410- 313-6110 and the Maryland Youth Camp Incident Report Form is completed (Appendix L).

In any situation where an injury, illness or fatality occurs which requires care by a physician, dentist, or camp nurse and as a result the student is treated or admitted to a medical facility, has laboratory analysis performed or undergoes an x-ray, the Maryland Youth Camp Injury or Incident Report Form will be completed in duplicate. The GCS Summer Camp Program Director will forward one copy to the Youth Camp Safety Advisory Council, Department of Health and Mental Hygiene. A copy of the report will be kept on file for at least three years.

I have reviewed the GCS Summer Camp Health Services Policy and Procedures 2024 and approve of these procedures for good medical care at a summer youth day camp.

Name: Amy L. Ro, RN MHSA	Title: GCS Head Nurse
RN License: R216325	Expiration: 11/28/2025
Address: 12793 Folly Quarter Road Ellicott City, MD 21042	Phone Number: 410-531-7327 Email: aro@glenelg.org

Amy Ro, RN MHSA
Signature

3/6/2024
Date

GCS HEALTH SERVICES ILLNESS AND INJURY POLICY
(APPENDIX A)

General Illness/Injury

- Students not feeling well should not be sent to school.
- Students should not come to school or return back to school until the following criteria is met:
  - **24 hours** following an episode of vomiting or diarrhea
  - **24 hours** fever-free without fever reducing medication (i.e., Tylenol or Motrin); GCS considers a fever anything above 100.0° F
  - **24 hours** of medications/antibiotics onboard if student is diagnosed with a contagious illness such as strep throat, conjunctivitis (pink eye), etc.
- **Within 30 minutes of notification of illness/injury, student must be picked up** by Parent/Guardian or Designated Contact.

Serious Injury

- In the event of a serious injury, the parent or person named as an emergency contact will be called immediately. If hospitalization is indicated and the parent cannot be reached, the child will be taken to the Howard County General Hospital emergency department, or the nearest facility, if off-campus, for treatment. Your initials on the Consent to Treat and subsequent signature authorizes Glenelg Country School to give first aid and/or transport your child to the nearest emergency room.

Parent/Guardian Communication

- Please inform the following people if your student will be absent from school:
  - Student's Division main office by 10 AM with a reason why your student will not be in school that day
  - Health Services team of any contagious illness by contacting nurses-mail@glenelg.org
- **After an absence of 3 consecutive school days due to illness/injury a note from a Health Care Provider is required for the student to return to school**
- If restricted for 3 days or less from school activities, competitive sports and/or physical education GCS requires written notification from the parent/guardian
  - If restricted for greater than 3 days from school activities, competitive sports and/or physical education, GCS requires written notification from a Health Care Provider indicating the duration of activity restriction. This written notification can be in either of the following forms: Letter from the Health Care Provider
  - PARN (Physical Activity Restriction Notification - GCS form)

COVID-19 Guidelines

- As of March 2024, Glenelg Country School will be adhering to the new CDC COVID guidance, which states the following when an individual tests positive for COVID:
  - Stay home and away from others while experiencing respiratory virus symptoms
  - Return to normal activities when, for at least 24 hours, both are true:
    - Your symptoms are getting better overall, and
    - You have not had a fever (and are not using fever reducing medications like Tylenol or Motrin)
  - Once normal activities are resumed, consider taking added precautions over the next 5 days such as:
    - Take additional steps for cleaner air

- Practice good hygiene, hand-hygiene
- Mask
- Physical Distancing
- Test when around other people indoors

GCS EMERGENCY AND HEALTH INFORMATION – EMPLOYEE
(APPENDIX B)

Last Name _____ First Name_____

Home Address _____
City _____State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____Date of Birth _____ Sex _____

Persons to be contacted in case of emergency:

1st Name _____Relation_____ Home Phone_____
Work Phone _____ Cell Phone _____

2nd Name _____Relation_____ Home Phone_____
Work Phone _____ Cell Phone _____

Physician's Name _____ Phone _____

Health Insurance Company _____ Policy Number_____

Significant Health Problems:
___ None ____ Asthma ____Diabetes ____Seizures ____Cardiac
___ Behavioral/Psychological
___ Other: _____

Allergies:
____Bee stings ____ Insect Bites ____Food ____Other: _____

Medications:
____Epi-Pen ____ Benadryl ____Other: _____

Protocol: _____

GCS TUBERCULOSIS SCREENING & TESTING POLICY
(APPENDIX C)

DEFINITION:
Tuberculosis (TB) as defined by the Center for Disease Control (CDC) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. TB disease was once the leading cause of death in the United States. TB is spread through the air from one person to another. The bacteria are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.

However, not everyone infected with TB bacteria becomes sick. People who are infected, but not sick, have what is called latent TB infection. People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB to others. But some people with latent TB infection go on to get TB disease.

There is good news. People with TB disease can be treated if they seek medical help. Even better, most people with latent TB infection can take medicine so that they will not develop TB disease.

PURPOSE
Tuberculosis continues to be a highly infectious, potentially life-threatening disease. According to the World Health Organization and the Centers for Disease Control, active TB disease can be prevented if screening is provided for those at high risk. Minimizing exposure to TB starts by identifying those with active and latent tuberculosis in our student population. Glenelg Country School has implemented the following prevention and treatment policies and requirements.

REQUIREMENTS:
All new students & returning students who need an annual physical exam (6th THRU 12TH grades)

- Complete the TB Screening on the Physical Exam Form
- The TB Screening needs to be completed with the Physical Exam and by a Physician or Nurse Practitioner
- If your provider needs further assistance in conducting the TB Screening, the GCS Pediatric Tuberculosis Risk Assessment, the GCS Pediatric Risk Assessment User Guide, and the list of Countries with High Burden of Active TB are provided as attachments to the Physical Exam Form
    - TB testing is recommended if any of the following criterion are met:
        1) Birth, travel, or residence in a country with an elevated TB rate for at least **1 month** within the past year,
        2) Immunosuppressed (current or planned), and
        3) Close contact to someone with infectious TB disease during lifetime

TUBERCULIN SKIN TEST:

- If TB testing is required, testing must be done **in the United States** and **prior to the first day of school**
- If the student has not had a previous positive TB skin test, a Mantoux tuberculin skin test (TST) can be done (results read within 48-72 hours)
    - A TST reaction of >10mm of induration is considered positive and requires follow-up (with a chest x-ray and/or the Interferon-gamma release assay [IGRA] blood test)
    - A TST that was not measured and recorded in millimeters (mm) of induration must be repeated
- If the student has had a positive skin test previously, DO NOT REPEAT THE TEST. A documented positive reaction to a past tuberculosis skin test is contraindicated to further skin tests

INTERFERON-GAMMA RELEASE ASSAY (IGRA):

- The IGRA does not cross-react to bacilli Calmette-Guerin (BCG) vaccine and is the preferred method of testing for persons who have received the BCG vaccination

TREATMENT & FOLLOW UP:

- Treatment for **active TB** (as diagnosed by a positive chest x-ray) must start prior to the first day of school
- Treatment for **latent TB** (as diagnosed by positive Interferon-gamma release assay [IGRA]) must start immediately
- Parents/guardians need to assume responsibility for adherence to any treatment plan
- Treatment options are to be discussed and determined with your physician
- Physician documentation of completion of treatment is required

POSITIVE TST:

- A TST reaction of >10mm of induration is considered positive and requires follow up with an IGRA blood test and/or chest x-ray
- Results of the chest x-ray need to be submitted to school prior to starting

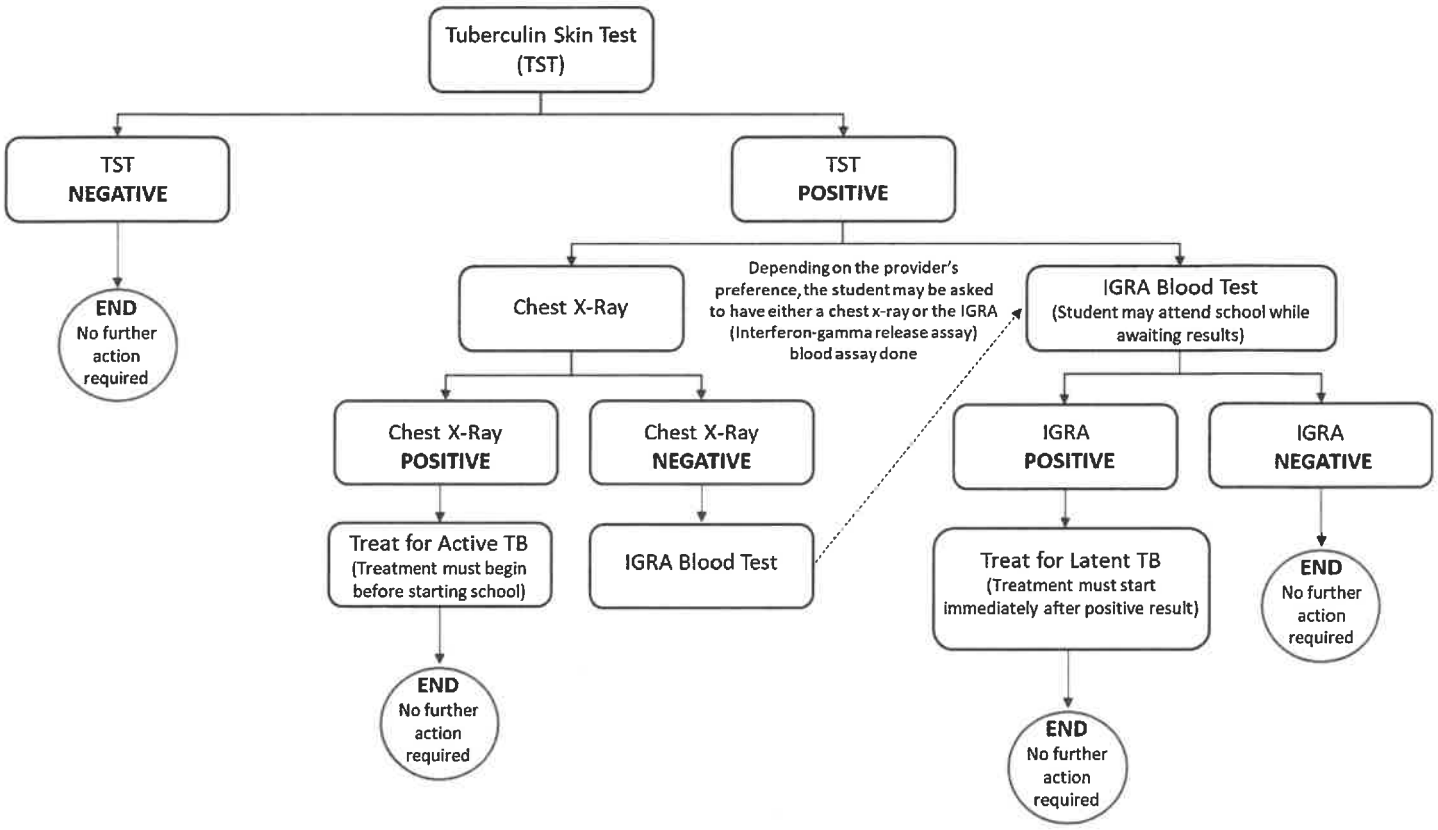
POSITIVE Chest X-Ray:

- Indicates active disease and immediate treatment must be implemented
- Treatment must start prior to starting school

POSITIVE IGRA:

- Requires treatment for latent TB, even if the chest x-ray is negative for active disease
- May attend school while waiting for results but must start treatment immediately following results

See below flowchart for further details:



GCS Pediatric Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic children for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
- Do not treat for LTBI until active TB disease has been excluded:
  For children with TB symptoms or abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures, and nucleic acid amplification testing.

LTBI Testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see Attachment B, Pediatric Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-US born persons ≥ 2 years old.

☐ **Immunosuppression,** current or planned

- HIV Infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g. infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 2mg/kg/day, or ≥ 15mg/day for ≥ 2 weeks) or other immunosuppressive medication.

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

GCS Pediatric Tuberculosis Risk Assessment based off the California Pediatric Tuberculosis Risk Assessment (September 2018) and guidance from the Howard County Health Department and the Maryland Department of Health.

GCS Pediatric Tuberculosis Risk Assessment User Guide

Avoid testing persons at low risk
Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors
Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is purposeful in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. Local TB control programs and clinics can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** Please visit the CTBCP website for more information. (https://phpa.health.maryland.gov/OIDPCS/CTBCP/pages/Home.aspx)

Most patients with LTBI should be treated
Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT). However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

When to repeat a risk assessment and testing
Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. Children who volunteer or work in health care settings might require annual testing and should be considered separately. Retesting should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression but could also include foreign travel.

Immunosuppression
The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Pediatric TB Risk Assessment are based on data in adults and in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence
Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child's return.

IGRA preference in non-U.S.-born children ≥2 years old

Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for non-U.S.-born children ≥2 years of age. IGRAs can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB
It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Emphasis on short course for treatment of LTBI
Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12-week regimen is not recommended for children <2 years of age or children on antiretroviral medications. It is under study in pregnancy. Drug- drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Refusal of recommended LTBI treatment
Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded, and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children 5 years or older and 3 months for children less than 5 years of age.

Symptoms that should trigger evaluation for active TB
Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

Resources
Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)
American Academy of Pediatrics, Red Book Online, Tuberculosis is available on the Red Book Online website. (https://redbook.solutions.aap.org/chapter.aspx?sectionid= 189640207&bookid=2205)

Abbreviations
AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin CXR= chest x-ray DOT= directly observed therapy IGRA=interferon gamma release assay LTBI= latent TB infection MDR =multiple drug resistant NAAT= nucleic acid amplification testing SAT= self-administered therapy TST= tuberculin skin test

GCS TB Pediatric Risk Assessment User Guide based off the California TB Pediatric Risk Assessment User Guide (September 2018) and guidance from the Howard County Health Department and the Maryland Department of Health.

Countries with High Burden of Active Tuberculosis

- The following countries are TB "high burden" countries.
- These countries have been given the highest priority at the global level.
- The high burden countries accounted for approximately 80% of all estimated incident cases worldwide.

High Burden Countries (used for the period 2021-2025)
Angola
Bangladesh
Brazil
China
Democratic Peoples Republic of Korea
Democratic Republic of Congo
Ethiopia
India
Indonesia
Kenya
Mozambique
Myanmar
Nigeria
Pakistan
Philippines
South Africa
Thailand
Uganda
Tanzania, United Republic of
Viet Nam
Central African Republic
Congo
Gabon
Lesotho
Liberia
Mongolia
Namibia
Papua New Guinea
Sierra Leone
Zambia

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MEDICATION POLICY

PRESCRIPTION AND NON-PRESCRIPTION PRODUCTS

(APPENDIX D)

MEDICATIONS WILL ONLY BE ADMINISTERED BY TRAINED MEDICAL STAFF

- Medication Administration General Guidance:
  - Please provide **UNEXPIRED** products **ONLY**.
  - Provide all prescription medications (i.e., inhalers) in the **original packaging with the pharmacy label attached.**
  - Provide all Over the Counter (OTC) medications in the **original packaging and/or container** (i.e., ibuprofen (Advil/Motrin), acetaminophen (Tylenol), diphenhydramine (Benadryl), antacids (TUMS), etc.); sunscreen and insect repellant is not considered an OTC medication.

- Prescription and OTC Medication Administration Requirements:
  - In order for the Camp Nurses to administer prescription and OTC medications, a **Medication Administration Authorization Form** for Youth Camps in Maryland (from the Department of Health & Mental Hygiene) much be completed.
    - *Part I - Prescriber's Authorization*: All sections need to be completed by the **Health Care Provider (HCP)/Prescriber.**
    - *Part II – Parent/Guardian Authorization*: All sections need to be completed by the **parent/guardian** with proper information and signature.
    - *Part III – Authorization for Self-Administration/Self-Carry*: All sections need to be completed and signed by **HCP/Prescriber AND parent/guardian** if camper is able to self-carry their medications (self-administration medications, mostly for emergency medications like inhalers or EpiPen's).

- Severe Allergy Medication Administration Requirements (Food Allergies, Insect Sting Allergies, etc.):
  - For any camper with a severe allergy requiring emergency medication administration (i.e., EpiPen) an **Allergy and Anaphylaxis Emergency Plan Form** must be completed.
    - All sections of Page 1 need to be completed by the **HCP/Prescriber** as well as signed by the **HCP/Prescriber.**
    - Page 1 also needs to be signed by the **parent/guardian**.
    - Page 2 needs to be completed by the **parent/guardian**.

NO EXCEPTIONS

Campers requiring auto injectable Epinephrine (i.e., EpiPen, Auvi-Q) MUST have their completed forms and medication checked into the Camp Health Room to attend camp. The camper may not attend camp without these requirements – the camper will be sent home.

- Medication Storage and Administration:
  - **Emergency medications** (i.e., EpiPen, inhaler) will be kept in the associated health room of the building the camp is being hosted in that week. All emergency medications are stored and locked up in the Health Room at the end of the day. In case of an emergency, the medication will be given first and then the Health Staff is called.
  - **OT medications, routine medications, and diabetic supplies** are stored in a locked cabinet in the Camp Health Room located in the Manor House.
    - The camper comes to the Camp Health Room when medication is to be administered.
    - The camper comes to the Camp Health Room when diabetic monitoring/correction is needed.

- Medication Drop-Off/Check-In with Camp Nurse:
  - All medications must be dropped-off by the parent/guardian and checked-in at the Camp Health Room located in the Manor House.
  - **A signature is required by the parent/guardian** when checking-in medications.
  - Self-carry medications still need to be checked-in by the parent/guardian.
  - Again, all medications (prescription and OTC) **must be in their original container/package**.
  - Medications must be checked-in **by the first day the camper attends**. **Early medication drop-off/check-in is available** prior to the start of camp. Please contact the Manor House Health Room for hours and camp nurse availability (410-531-7327).

- Medication Pick-Up:

  Who: All medications must be **picked up and signed out by a parent/guardian**.

  When: **Every Friday at the end of the day** medications are available for pick-up. Please pick-up your camper from carpool, park your vehicle, and walk in the Manor House to get the camper's medications.

  Where: Manor House Health Room

  PLEASE NOTE: If the camper attends After Care, please pick up your medications from the Coordinator in the Manor House when you pick up your camper.

  If you are picking medications up on a day other than Friday, please make arrangements with the Health Staff (Manor House Health Room, 410-531-7327).

MEDICATIONS NOT PICKED UP BY 6PM ON THE LAST DAY OF CAMP WILL BE DISCARDED

Asthma Action Plan/Medication Authorization Form
(APPENDIX E)

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM
for Youth Camps in Maryland

Page 1 of 2

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/_____	3. PEAK FLOW PERSONAL BEST:

4. ASTHMA SEVERITY (check one): ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other_____

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.

6a. FROM (mm/dd/yyyy) ___/___/_____

6b. TO (mm/dd/yyyy) ___/___/_____

GREEN ZONE - DOING WELL

You have **ALL** of these
- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- **If known, peak flow greater than _____ (80% personal best)**

Medication Name	Dose	Route	Frequency	OK to Self-Administer
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

Exercise Zone

☐ Prior to all exercise/sports
☐ When the child feels they need it

Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

YELLOW ZONE - GETTING WORSE

You have **ANY** of these
- Some problems breathing
- Wheezing, noisy breathing
- Tight chest
- Cough or cold symptoms
- Shortness of breath
- Other:_____
- **If known, peak flow between ____ and _____ (50% to 79% personal best)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these
- Breathing hard and fast
- Lips or fingernails are blue
- Trouble walking or talking
- Medicine is not helping (15-20 mins?)
- Other:_____
- **If known, peak flow below _____ (0% to 49% personal best)**

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

MDH-4758-C (01/2019)

Please turn over - this form has 2 pages with four total sections

Keep for 3 Years

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ___/___/___

Section II. PRESCRIBER'S AUTHORIZATION

8. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. HOME PHONE #	10e. CELL PHONE #	10f. WORK PHONE #

Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I: Asthma Action Plan* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I: Asthma Action Plan*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	11b. DATE (mm/dd/yyyy)
12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	12b. DATE (mm/dd/yyyy)

Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:	
Reviewed by:	DATE (mm/dd/yyyy)

Allergy Action Plan/Medication Authorization Form
(APPENDIX F)

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	Give this Medication: Epinephrine	Antihistamine
But is *not* exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Medication		Dose:
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer (school-aged only) ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

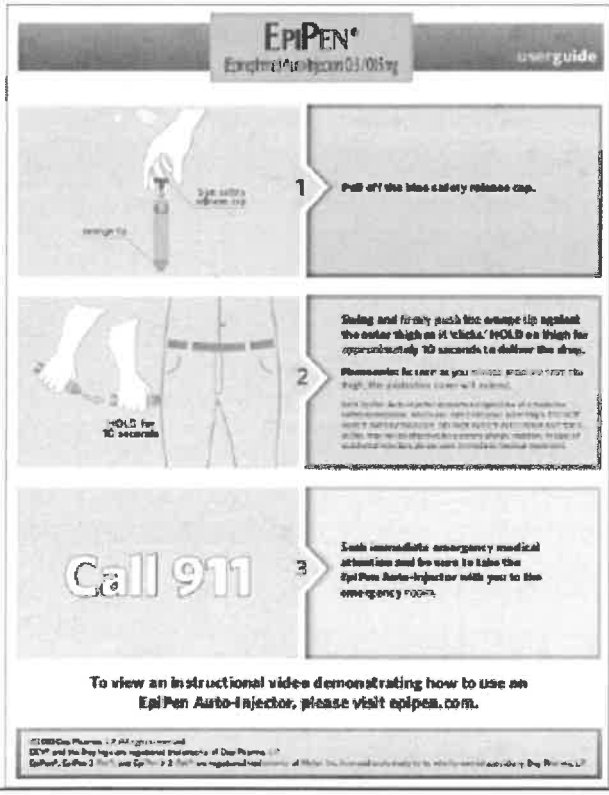
CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last)

2. DATE OF BIRTH (mm/dd/yyyy) ___/___/____

3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.

3a. FROM (mm/dd/yyyy) ___/___/____

3b. TO (mm/dd/yyyy) ___/___/____

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No* *Known side effects:*				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No* *Known side effects:*				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ *Yes* ☐ *No* *Known side effects:*				

4. PRESCRIBER'S NAME/TITLE

TELEPHONE FAX

ADDRESS

CITY STATE ZIP CODE

This space may be used for the Prescriber's Address Stamp

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
(original signature or signature stamp only)

5b. DATE (mm/dd/yyyy)

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

6a. PARENT/GUARDIAN SIGNATURE

6b. DATE (mm/dd/yyyy)

6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE #

6e. CELL PHONE #

6f. WORK PHONE #

Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE
FOR SELF-ADMINISTRATION/SELF-CARRY

7b. DATE

8a. PARENT/GUARDIAN'S SIGNATURE
FOR SELF-ADMINISTRATION/SELF-CARRY

8b. DATE

MDH-4758-A (01/2019)

Medication Authorization Form
(APPENDIX G)

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Nonprescription medication must be in the original container with the instructions for use. Non prescription medication includes vitamins, homeopathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417
Draft Revision Date: 4/4/2018

Section I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME (First Middle Last) | 2. DATE OF BIRTH (mm/dd/yyyy) ___/___/____

3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR. | 3a. FROM (mm/dd/yyyy) ___/___/____ | 3b. TO (mm/dd/yyyy) ___/___/____

	Medication Name	Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)
1						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
2						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				

4. PRESCRIBER'S NAME/TITLE

TELEPHONE FAX

ADDRESS

CITY | STATE | ZIP CODE

This space may be used for the Prescriber's Address Stamp

5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) | 5b. DATE (mm/dd/yyyy)

Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA

6a. PARENT/GUARDIAN SIGNATURE | 6b. DATE (mm/dd/yyyy) | 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

6d. HOME PHONE # | 6e. CELL PHONE # | 6f. WORK PHONE #

Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I* above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in *Section I*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 7b. DATE | 8a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY | 8b. DATE

MDH-4758-A (01/2019)

ASTHMA STANDARD OF CARE PROCEDURES
(APPENDIX H)

DEFINITION:

Asthma is a chronic condition that affects about 10% of children at some time during childhood. It is one of the leading causes of missed days from school. Asthma can be a serious and life-threatening condition. However, for most children, asthma can be controlled.

Asthma is a chronic lung disease characterized by acute episodes or attacks of breathing problems such as: coughing, wheezing, chest tightness, and shortness of breath. These symptoms are caused by airway swelling, blocked, or narrowed airways, increased production of thick mucus, and increased responsiveness of the airways to a variety of stimuli or "triggers." For this reason, asthma is also called reactive airway disease (RAD).

Some of the common triggers are:

- Viral infections: upper respiratory infections such as the common cold, influenza, or sinus infection
- Exercise, especially in cold weather
- Allergens: most common are pollen, dust mites, animal fur/dander, and feathers
- Environmental irritants: smoke, aerosol sprays, chalk dust, paint and varnish fumes, perfume, and air pollution
- Emotions, if they lead to an outburst of laughing, crying, or yelling

SYMPTOMS/POSSIBLE OBSERVATIONS:

MILD ASTHMA SYMPTOMS

- Cough
- Mild wheeze
- Mild chest tightness
- Shortness of breath with activity but not at rest
- Slight increase in respirations
- Prolonged expiration
- Peak flow 70-90% of baseline

MODERATE ASTHMA SYMPTOM

- Loud wheeze while at rest and during activity
- Coughing while at rest and during activity
- Chest tightness while at rest and during activity
- Shortness of breath while at rest and during activity
- Diminished breath sounds
- Difficulty breathing
- Nasal flaring
- Retractions

- Increased respiratory rate
- Prolonged expiration
- Increased heart rate
- Laryngitis
- Pale skin coloring
- Anxiousness, restlessness, and apprehension

SEVERE ASTHMA SYMPTOMS

- Severe shortness of breath while at rest and during activity
- Wheeze while at rest and during activity (wheeze may also disappear)
- Cough while at rest and during activity
- Chest tightness while at rest and during activity
- Retraction of muscles in neck and chest
- Skin color cyanotic (bluish color of nail beds and around mouth)
- Inaudible breath sounds
- Fatigue
- Difficulty walking (100 feet) and talking (needing a deep breath often)
- Sweating
- Increased respiratory rate (greater than 30 per minute/at rest)
- Increased heart rate (greater than 120 per minute/at rest)

ACTION/ASTHMA MANAGEMENT

NOTE: Campers who experience breathing problems for the first time may be experiencing anaphylaxis, pneumonia, foreign body obstruction, etc. **Activate 911 for students without a known history of asthma who are experiencing breathing difficulty.**

Effective management of asthma at camp and at home is necessary to promote a supportive learning environment, reduce absenteeism, reduce classroom disruption, provide necessary emergency support, and achieve full participation in physical activities. Appropriate staff counselors should be aware of students with asthma.

Asthma Management at Camp

- Anyone assisting in entering camp registration information should notify the camp nurse when a registration indicates the need for a rescue inhaler or a nebulizer at camp. The camp nurse will follow up with the parent regarding the asthma medication order ensuring the camper's asthma is stable to attend camp.
- Should a camper present with symptoms of respiratory distress the counselor should alert the camp nurse via the walkie-talkie.
- Assist the camper in his/her use of their rescue inhaler, if available.
- Upon arrival the nurse will:
  - Encourage and assist the camper to assume an upright position with the shoulders relaxed
  - Support both arms on pillows if desired.

- Communicate with the student in a calm and reassuring manner.
- Instruct and reinforce belly breathing with student (Inhale slow deep breaths through nose and exhale slowly through pursed lips).
- Encourage student to drink room temperature water or clear juice (not milk).
- Continue to encourage belly breathing and fluid intake.
- Notify the parent/guardian if medication does not resolve symptoms.
- Call 911 for any student experiencing severe asthmatic symptoms and not responding to treatment.
- Inform the Camp Director
- Document

Physical Activity and Asthma

Campers should not be restricted from physical activity because they have asthma. They can and should exercise when they are feeling well and are symptom-free. If a recent illness precludes full participation, less strenuous activity should be permitted. Certain measures can minimize asthma problems while exercising.

- Administer prescribed inhaled medication prior to exercise, if ordered.
- Encourage the camper to perform warm up and cool down exercise before and after activity.

Medication Administration

Camp counselors will only be allowed to assist the camper with the use of inhalers. Campers with greater need will be sent to the Camp Health Office. Campers who self-carry asthma medication still need to be evaluated by the Camp Health Office.

- Administer medication only with a signed physician order and accompanied by parent/guardian signature in accordance with Camp Health Services Medication Procedure.
- Determine the order in which the medications must be administered if more than one asthma medication is received. Groups of medications commonly used to treat asthma are bronchodilators, corticosteroids, and anti-inflammatory drugs.
- Administer these medications by the route ordered: by mouth, by rescue inhaler, or by nebulizer.
- Inhalers for Asthma and other airway constricting conditions and EpiPen's are the only form of medication that students are routinely permitted to carry as directed by the physician/prescriber.

Nebulized Treatment

Performed in the Camp Health Office by the camp nurse.

A nebulizer is an air compressor, which administers medication directly to the airways of students who do not respond adequately to the use of rescue inhalers, or need this method due to age, disease, or compliance factors.

Albuterol nebulizer treatments are considered aerosol-generating procedures and pose a very

high exposure risk due to potentially infectious aerosols sprayed into the air and throughout the room during the treatment. Albuterol nebulizer treatments will be given during emergencies only.

If a camper has an asthma flare-up that may require a nebulizer treatment, the student should stay home and not be at camp. Albuterol inhalers, with or without a spacer chamber, are still acceptable at camp when needed. Inhalers are not aerosol-generating and do not pose a high exposure risk.

Resources Available to Camp

The National Asthma Education and Prevention Program
(NAEPP) National Heart, Lung, Blood Institute (NHLBI)
4733 Bethesda Avenue, Suite 530
Bethesda, MD 20714-4820
Phone: 301-251-1222

American Lung Association of Maryland, Inc. 1-800- LUNG-USA (1-800-586-4872)
National Capital Area
14435 Cherry Lane Court, Suite 310
Laurel, MD 20707
Phone: 301-483-3164, 1-800-445-6016
Or
1840 York Road
Timonium, MD 21093
Phone: 410-560-2120; 1-800-492-7527

Asthma and Allergy Foundation Maryland- Greater Washington DC Chapter
1777 Reisterstown Rd. Suite 290
Baltimore, MD 21208 Phone: 410-653-2880

MEDICATION ADMINISTRATION RECORD

(APPENDIX I)

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION

KEEP FOR 3 YEARS

GCS Medication Receiving/Disposing Record

(APPENDIX J)

Student Name:	Camp:

Record of Medication Receiving/Check-in

Medication/Equipment Name	Date Received	Amount Received	Signature of Person Accepting Medication	Signature of Parent/Witness	Expiration Date of Medication	Auth to Self-Carry	Supply in Health Room

Record of Wasted or Destroyed Medication

Medication	Number/Amount Wasted	Date	Reason For Wasting	Signature of Person Wasting Medication	Signature of Witness

Medication Returned to Parent

Medication(s) Picked Up by Parent:
Date:
Signature of Person Returning Medication to Parent:
Signature of Parent:

GCS SUMMER CAMP HEALTH ROOM VISIT FORM
(APPENDIX K)

Dear Parent,
This is to inform you that your child _____ Camp_____
was seen by the camp nurse today _____ for complaint(s) of:

_____ Fever
Temp. was _____
_____ Sore Throat
_____ Stomachache
_____ Rash
Location _____

_____Earache
Right Ear Left Ear
_____ Asthma Symptoms
Inhaler/ nebulizer used
at_____
_____ Injury _____

_____ Headache

_____ Cough
_____ Nosebleed
_____ Eye Drainage/Redness/
Itching
Right Eye Left Eye
_____ Cramps

_____ Other _____

If a **HEAD INJURY was noted to have occurred refer to page 3 for symptoms and advice as to when to contract your doctor.

CARE GIVEN:_____
_____
_____

_____ **RE-CHECK** this condition on arrival at home and seek medical care if condition worsens or if the symptoms change.

_____ **Have your child evaluated by a physician** and complete page 2 of this form.

Camp Nurse: _____ Date: _____
MH Health Room: 410-531-7327 Fax: 410-531-8607

TO RETURN TO CAMP

- Child **MUST BE** fever free for 24 hours without fever reducing medication
- **NO diarrhea or vomiting** for 24 hours from time of school incident
- Must be on antibiotics for 24 hours if prescribed (especially strep throat, pink eye)
- A written note must be sent to the nurse if diagnosed with a contagious disease, placed on antibiotics, any restriction of activity or absent for 3 or more days

If your child was seen by a doctor, PLEASE have a physician complete and sign below. Return signed form to the nurse. Thank you.

My child _____ was seen by Doctor _____ and diagnosed with _____.

_____ Is on medication _____
_____ No restrictions
_____ Has the following restriction _____
_____
_____

Parent Signature & Date: _____

Physician's Signature & Date: _____

HEAD INJURY INFORMATION

Minor Head Injuries

Many minor head injuries that do not involve loss of consciousness or amnesia may be treated at home. A person who has had a head injury should be watched for any problems from the injury. Home treatment can also help relieve swelling and bruising of the skin or scalp and pain caused by a minor head injury.

If a visit to your doctor is not needed immediately:

- Apply ice or cold packs to reduce the swelling. A "goose egg" lump may appear anyway, but ice will help ease the pain.
- You may use acetaminophen, such as Tylenol, to relieve a mild headache or pain from the injury.

Watch:

- The injured person should be watched by a responsible adult for the next 24 hours.
    - **Call 911or go to an emergency room immediately** if unconsciousness or seizure activity develops.
    - Seek medical care if any new symptoms develop after the injury (post-concussive syndrome) such as:
        - Vomiting,
        - Worsening headache,
        - Blurred or double vision, or
        - Unsteadiness
        - Drowsiness or confusion
        - Behavior changes
        - Slurred speech

Rest:

- Rest is the best treatment for a concussion. Get plenty of sleep at night and take rests during the day.
- If a mild to moderate headache develops, lie down and try to relax your entire body.
- Take only acetaminophen, such as Tylenol, to relieve a mild headache or pain from the injury. Do not use other nonprescription or prescription medicines for pain without approval from your doctor.

MARYLAND YOUTH CAMP INCIDENT REPORT FORM
(APPENDIX L)

MARYLAND YOUTH CAMP INCIDENT REPORT FORM

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1606
Phone 410-767-8417 Toll Free 1-877-463-3464, ext.78417 Fax 410-333-8926

A. PERSONAL INFORMATION *Complete Section A for all incidents.*

Name (DO NOT INCLUDE NAME ON COPY SENT TO MDH)	A1. Age	A2. Gender ☐ Male ☐ Female	A3. Check One ☐ Day Camper ☐ Residential Camper ☐ Camp Employee ☐ Other.

B. INCIDENT INFORMATION *Complete Section B for all incidents.*

B1. Report Type (check one)
☐ Injury (Complete C) ☐ Illness (Complete D) ☐ Medication Error (Complete E)
☐ Epinephrine Use (Complete F) ☐ Mental Health (Complete A & B only)

Date and Time of Incident/Illness Onset
B2. Date: _____
B3. Time: ____ : ____ ☐ AM ☐ PM

B4. Provide short description, do not include names: ☐ *Additional information attached*

B5. Did the incident require any of the following: AED. ☐ No ☐ Yes CPR ☐ No ☐ Yes

B6. Was the person transported off-site for medical care?
☐ No ☐ Yes, complete A. and B.
A. Transported by:
☐ Camp vehicle ☐ Personal vehicle
☐ Ambulance ☐ Helicopter
B. Treated or evaluated at (check all that apply, specify the name of facility)
☐ Urgent Care ☐ Doctor's Office
☐ Hospital ☐ Other
(specify) _____

B7. After off-site or on-site medical evaluation, the person (check all that apply):
☐ Was admitted to the hospital
☐ Went home. Date
☐ Returned to camp with medical restrictions
☐ Returned to camp with no restrictions
B8. Did incident result in death?
☐ No
☐ Yes List Date of death: / /
List Time of death: ☐ am/☐ pm

B9. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?
☐ No ☐ Yes
B10. Did the incident prompt a report or investigation by government authorities or officials?
☐ No
☐ Yes (specify)
Government Agency _____
Report/Investigation Date _____
Report/Investigation Number _____

C. INJURY (15 through 22)
C1. What caused the injury (check one, specify below)
☐ Bite ☐ Burn
☐ Contact/collision with ☐ Person or ☐ Object
☐ Drowning ☐ Near-Drowning
☐ Fall ☐ Trip/Slip
☐ Hazardous Material Exposure
☐ Poisoning ☐ Weapon ☐ Other (specify)
specify by what _____

C2. Was the injury:
☐ Unintentional (accidental)
☐ Intentional (self-inflicted)
☐ Intentional (inflicted by another)

C3. Did the individual sustain a (check all that apply):
☐ Concussion ☐ Other Head Injury
☐ Spinal Cord Injury ☐ Loss of Consciousness
☐ Severe Laceration ☐ Fracture
☐ None of above

C4. Specify the body part(s) injured: _____

C5. Injury occurred.
☐ On Site ☐ Off Site
(specify location) _____

C6. Specify the activity the individual was engaged in at the time of injury (select most applicable activity):
☐ Archery
☐ Arts & Crafts
☐ Biking
☐ Boating (specify) _____
☐ Competitive Sport/Game (specify). _____
☐ Cooking/Food Preparation
☐ Fighting
☐ General Camp Life (specify) _____
☐ Groundskeeping/Maintenance (staff only)
☐ Gymnastics/Dance/Cheerleading
☐ Horseback Riding

C6. Continued
☐ Motorized Vehicle (specify) _____
☐ Playground
☐ Primitive Camping
☐ Riflery
☐ Rock Climbing/Rappelling
☐ Ropes Course/Challenge Course/Zip-line
☐ Swimming
☐ Walking/Running/Hiking
☐ Other (specify) _____

C7. Was the activity supervised?
☐ Not Applicable ☐ No
☐ Yes (specify) # of campers in activity _____
# of staff in activity _____
C8. Was the individual using safety equipment?
☐ No ☐ Not Applicable
☐ Yes (specify) _____

D. ILLNESS D1. MDH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department
A. Was the illness a suspected reportable disease, condition or outbreak? ☐ No ☐ Yes
For the required MDH reportable diseases list and outbreak information go to: http://phpa.health.maryland.gov/IDEHA/SharedDocuments/what-to-report/ReportableDisease_HCP.pdf
B. Was the illness reported to a local health department? ☐ No ☐ Yes If Yes (specify department) _____
The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to:
http://phpa.health.maryland.gov/IDEHA/SharedDocuments/what-to-report/DeIMH1140.pdf

E. MEDICATION ERROR E1. Right Patient? ☐ No ☐ Yes, Right Medication? ☐ No ☐ Yes Right Time? ☐ No ☐ Yes Right Dose? ☐ No ☐ Yes Right Route? ☐ No ☐ Yes
E2. Type of administration: ☐ Self-Administration Was camp staff supervising the self-administration? ☐ No ☐ Yes Was medication secured? ☐ No ☐ Yes
☐ Staff administration Staff person's training level (check one) ☐ Office of child care (6 hour course) ☐ Certified Medication Technician ☐ LPN ☐ RN ☐ CNP

F. EPINEPHRINE USE F1. Who administered the epinephrine? Name and Title: _____
F2. Was the epinephrine prescribed to the individual? ☐ or the Camp, Epinephrine Certificate Holder? ☐ No ☐ Yes
F3. Trigger: ☐ Unknown or ☐ Known (specify) _____
F4. Symptoms (check all that apply): ☐ Skin reaction, ☐ Feeling of warmth ☐ Sensation of a lump in the throat, ☐ Constriction of the airway, swollen tongue, trouble breathing.
☐ Rapid pulse ☐ Nausea, vomiting or diarrhea ☐ Dizziness or fainting

G. CAMP INFORMATION G1. Report Completed By Employee Name (print) Title

G2. Camp Name Address MDH CAMP ID #

Notification					
	Parent, Guardian, or Emergency Contact was notified	☐ No ☐ Yes		Date	Method
	Camp Health Supervisor was notified	☐ No ☐ Yes ☐ Not Applicable	Health Supervisor Name	Date	Method
	MDH/CHS was notified within 24 hours	☐ No ☐ Yes ☐ Not Applicable	MDH Contact Name	Date	Method

G4. Employee Signature Date Phone Number

MDH-4782 4/2019 Maintain this report for at least 3 years