HEALTH CONCERNS & EMERGENCY ACTION PLANS

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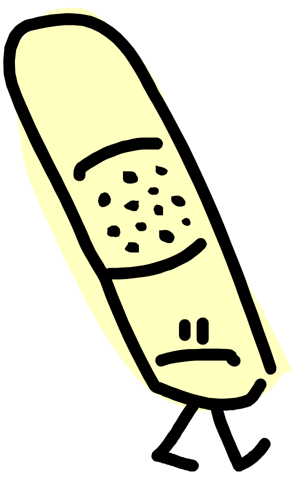
Main Health Concerns

- Allergy

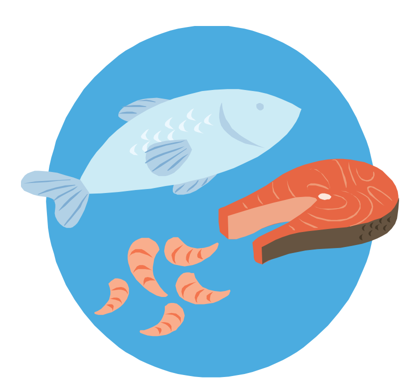
- Asthma
- Seizure

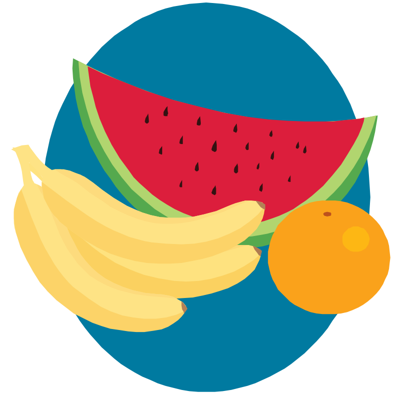
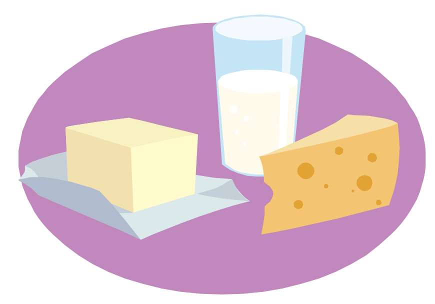
Allergies

- Most common health concern
- Defined as a hypersensitivity of the immune system
- 4 main types of allergies
  - **Food**
  - **Seasonal**
  - **Pet**
  - **Other**



OUR FOODS



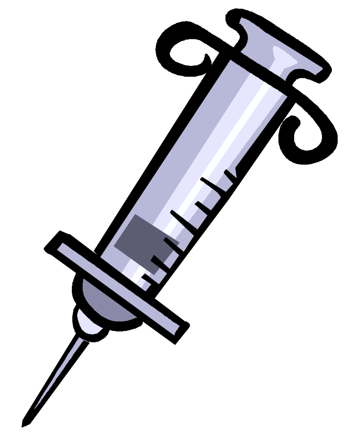
Food Allergies

- Most common allergy
- Affects 1 in 13 children
- 8 foods account for 90% of food allergies
  - Peanuts
  - Tree Nuts
  - Soy
  - Milk
  - Eggs
  - Wheat
  - Fish
  - Shellfish

- No Cure – only strict avoidance of food allergens is the only safe course of action

Anaphylaxis

- **Anaphylaxis** refers to a rapidly developing and serious allergic reaction that affects a number of different body systems at one time. Severe anaphylactic reactions can be fatal.
- Epinephrine (adrenaline) is a medication given to reverse the symptoms of anaphylaxis.
  - Should be administered following emergency action plan
- Teens and young adults are at the highest risk for fatal, food-induced anaphylactic reactions.
- Anaphylaxis can affect the following:
  - Skin
  - Nose
  - Mouth/throat
  - Respiratory Tract
  - Gastrointestinal Tract



Best Practices for Food Allergies

- Have a "No Sharing" policy
- Plan ahead so that the camper with food allergies may be safely included in all activities
- Review medical documentation provided by the parents
- Make sure all individuals that come into contact with the camper are aware of the allergy and how to respond appropriately
- Create prevention protocols
- Ensure all staff are familiar with medication and administration of medication

FORMS
Emergency Action Plans

- Parent/caregiver must complete prior to child starting camp!!!
- MUST BE SIGNED!!!
- A child does not have to have a disability to have an Emergency Action Plan completed
- 3 main Emergency Action Plans
  1. Allergy
  2. Asthma
  3. Seizure
- Also Include:
  1. Medical Release
  2. Consent for Treatment
  3. Authorization for Medication

Allergy Action Plan

CHILD'S NAME:______________________________ D.O.B.:___________________

TEACHER:___________________________________

ALLERGY TO:____

____

ASTHMATIC ☐ yes* ☐ no *High risk for severe reaction

☑ Check signs of allergic reaction pertinent to your child

☐	MOUTH	itching & swelling of the lips, tongue or mouth
☐	THROAT	itching &/or a sense of tightness in the throat, hoarseness and hacking cough
☐	SKIN	hives, itchy rash and/or swelling about the face or extremities
☐	GUT	nausea, abdominal cramps, vomiting and/or diarrhea
☐	LUNG	shortness of breath, repetitive coughing and/or wheezing
☐	HEART	"thready" pulse, "passing out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation. ☐ **yes** ☐ **no**

ACTION FOR MINOR REACTION:

1. If symptoms are:____, give my child____

medication/dose/route

Then call:

2. Mother_______________________, Father_____________________or emergency contact
3. Dr. __________________________________ at ___________________________________

If condition does not improve within ten minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION:

1. If ingestion/contact is suspected and/or symptom(s) are: _________________________ _____________________ give _____________________________________ IMMEDIATELY!

medication/dose/route

Then call 911

2. Rescue Squad (ask for advanced life support)
3. Mother ______________________, Father ____________________, or emergency contact
4. Dr. _________________________________ at ____________________________________

Parent Signature ___________________________________ Date _______________

Physician's Signature ______________________________ Date _______________

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ______________________ D.O.B.: __________

Allergy to: ______________________

Weight: __________ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] **If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.**

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] **If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: ______________________

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: ______________________

Antihistamine Dose: ______________________

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

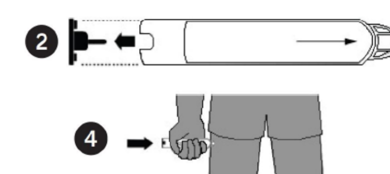
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

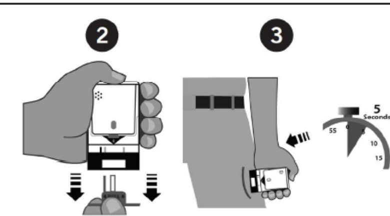
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



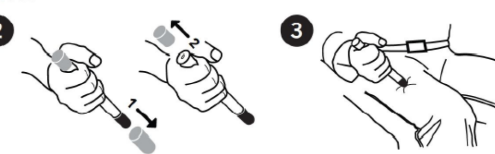
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ______________________

DOCTOR: ______________________ PHONE: ____________

PARENT/GUARDIAN: ______________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

NAME/RELATIONSHIP: ______________________

PHONE: ______________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

Asthma Action Plan

Child Name: ______________________ DOB: __________ Teacher: ________________

Emergency Contact: ____________________________ Phone: ________________

Severity Classification	Triggers	Exercise
← Mild Intermittent ← Moderate Persistent ← Mild Persistent ← Severe Persistent	← Colds ← Smoke ← Weather ← Exercise ← Dust ← Food ← Animals ← Air Pollution ← Other ________________	1.Pre-medication (how much and when) ________________ 2.Exercise modifications ________ ________________

GREEN ZONE: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work and play
- ☐ Sleeps all night

Peak Flow Meter
More than 80% of personal best or _______

Control Medications

Medicine	How Much to Take	When to Take It
________	________	________
________	________	________
________	________	________

YELLOW ZONE: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- ☐ Some problems breathing
- ☐ Cough, wheeze or chest tight
- ☐ Problems working or playing
- ☐ Wake at night

Peak Flow Meter
Between 50 to 80% of personal best or
_______ to _______

Continue Control Medicines and add:

Medicine	How Much to Take	When to Take It
________	________	________
________	________	________
________	________	________

If your symptoms (and peak flow, if used) return to Green zone after one hour of the quick relief treatment, THEN
← Take quick-relief medication every 4 hours for 1 to 2 days
← Change your long-term control medicines by
____
← Contact your physician for follow-up care

If your symptoms (and peak flow, if used) DO NOT return to GREEN ZONE after 1 hour of the quick relief treatment, THEN
← Take quick-relief treatment again
← Change your long-term control medicines by
____
← Call your physician/Health Care Provider within _____hours of modifying your medication routine

RED ZONE: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- ☐ Lots of problems breathing
- ☐ Cannot work or play
- ☐ Getting worse instead of better
- ☐ Medicine is not helping

Peak Flow Meter
Between 0 to 50% of personal best or
_______ to _______

Continue Control Medicines and add:

Medicine	How Much to Take	When to Take It
________	________	________
________	________	________
________	________	________

Go to the hospital or call for an ambulance if
← Still in the red zone after 15 minutes
← If you have not been able to reach your physician/health care provider for help
← ________________

Call an ambulance immediately if the following danger signs are present
← Trouble walking/talking due to shortness of breath
← Lips of fingernails are blue

Seizure Action Plan

CHILD'S NAME:______________________________D.O.B.:______TEACHER:__________________________
Description of seizure condition/disorder:____

Describe what your child's seizures look like: (1) what part of the body is affected? (2) How long does it last? _____

Describe any know "triggers" (behavior and /or symptoms) for seizure activity: _____________________

Detail the time and duration of child's typical seizure activity: _____________________________

Has the child been treated in the emergency room due to seizures? ☐ yes ☐ no How many times?_____
Has the child stayed overnight in the hospital due to their seizures? ☐ yes ☐ no How many times?_____

Planned strategies to support the child's needs and safety issues when a seizure occurs:
(diapering/toileting, outdoor play, nap/sleeping, etc) ____

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn if prescribed.	Decrease possibility of injuries related to seizure activity.
At risk for aspiration of respiratory secretions or vomitus during seizure activity.	If a seizure occurs, staff will roll the child onto his/her side.	Decrease possible aspiration during seizure activity.
Self esteem disturbance related to occurrence of seizure or use of protective helmet .	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any reactions. Reassure the other children in the group that the child will be all right if a seizure occurs.	Increase child's successful adaptation to requirements of living with a seizure disorder. The child will demonstrate a positive attitude Toward learning activities. Other children will feel safe.
Parent and child may not be Aware of possible triggers.	Staff will document the occurrences of any seizure activity on attached *Seizure Activity Log*	Parent, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after seizure, then will allow the child to sleep and/or rest after seizure.	The child may safely sleep/rest if needed, after seizure occurs.

Medications to be administered: ☐ yes ☐ no *specify administration method, time schedule, side effects*
Type of medication: ____

Additional Information: (include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)_

Emergency Procedure

Call 911 if: ☐ seizure is longer than ____________ minutes ☐ child is unresponsive after seizure
☐ color changes ☐ other : ______________________________

Emergency Contact: ___________________________ Telephone:_____________________________

This Seizure Action Plan will be updated/revised whenever medications of child's health status changes.

Parent Signature ___________________________________ Date ______________

Medical Release

Name of Child: ______________________ Age: ________ Date of Birth: ______________

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I/We may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give *(SITE NAME)* staff and faculty the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that *(SITE NAME)* shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Villa Lyan. I understand that this form is in effect from the date signed and that it is my responsibility to inform *(SITE NAME)* of any changes to this form.

Signature of Mother/Legal Guardian: ______________________ Date: __________

Mother's Name: ______________________ Home Phone: ______________________

Address: ______________________ Cell Phone: ______________________

City/State/Zip: ______________________ Work Phone: ______________________

Signature of Father/Legal Guardian: ______________________ Date: __________

Father's Name: ______________________ Home Phone: ______________________

Address: ______________________ Cell Phone: ______________________

City/State/Zip: ______________________ Work Phone: ______________________

Pediatrician's Name: ______________________ Telephone Number: ______________________

Hospital Preference: ______________________ Telephone Number: ______________________

Address: ______________________ City/State/Zip: ______________________

Insurance Company: ______________________ Policy/Group #______________________

Date of Minor's Last Tetanus Shot: ______________________ List Current Medications: ______________________

Allergies: ______________________ ______________________

______________________ ______________________

Medical history or other important fact that should be known: ______________________

____

____

Consent for Treatment

I, ____ the parent and/or guardian of
Parent/Legal Guardian Name

________________________________, give my consent to *(SITE NAME)*
Student's Name

to administer treatment to my child.

Furthermore, in case of an injury or illness that is life threatening or in need of emergency treatment, I authorize the *(SITE NAME)* staff to summon any and all professional emergency personnel to attend, transport, and treat the student and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnostic, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to participate in the state in which such treatment is to occur.

I authorize the *(SITE NAME)*staff to administer topical Benadryl ointment/cream to my child in case of redness, swelling, itching, and/or mild rash as a result of external allergens (e.g. cats, horses, dust, bug bites, detergent, soap, and any other allergens). I will provide Villa Lyan and/or Creative Children Therapy with a detailed list of any and all allergies of the student.

Student's Name ____________________________

Mother's Name ____________________________ Home Phone: _______________

Address: ____________________________________ Cell Phone: _______________

Signature of Mother/Legal Guardian ___________________________ Date ______

Father's Name ____________________________ Home Phone: _______________

Address: ____________________________________ Cell Phone: _______________

Signature of Father/Legal Guardian ___________________________ Date ______

FIRST AID
&
CPR
CERTIFICATION

RESPONSE METHODS

- Become familiar with response methods pertinent to different emergencies
- Implement in a calm and professional manner

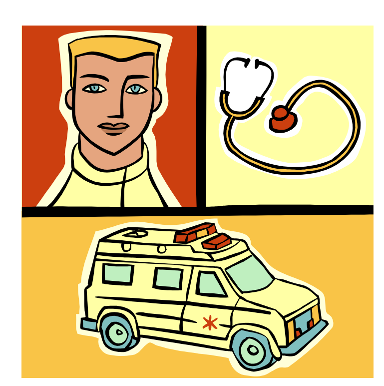
SAFETY AWARENESS

- Fundamental parts of your job as an employee
  1. Risk management
  2. Safety Awareness
  3. Emergency Response

EMERGENCY PHONE LIST

- Should include:
  1. First individuals to be notified
  2. Secondary individuals to be notified

ACTIVATING 911 SYSTEM



- What is your 911 system?
- Create an action plan delineating the steps to follow and the individuals to contact
- Time and effectiveness can lead to a better resolve and outcome of any situation

INCIDENT REPORTS

- Need to complete AS SOON AS POSSIBLE
- Complete for any type of incident
- Need to include:
  - Name of employee reporting
  - Witness
  - Supervisor Signature
  - Provide a copy to parent/caregiver

Incident Report Form

Staff's Name Reporting Incident: ________________________________ Date: ____________

1. Who was involved in the incident?

____

2. Please describe the incident:

____

____

____

____

____

3. Did any injuries, illnesses occur as a result of incident? ____ YES ____ NO

If **YES**, please describe: ____

____

Course of Action Taken: ____

____

4. Location of incident: ____

5. When did the incident occur?
Date: ____/____/____ Time: ________ AM PM (Circle One)

6. Did anyone witness the incident? _____ YES _____NO

If YES, please list names/position: ____

____

7. Did you report the incident? ____ YES ____NO

If **YES**, to whom did you report it to? *Parent* *Caregiver* (Circle One)

Other: ____

If **NO**, why did you not report it? ____

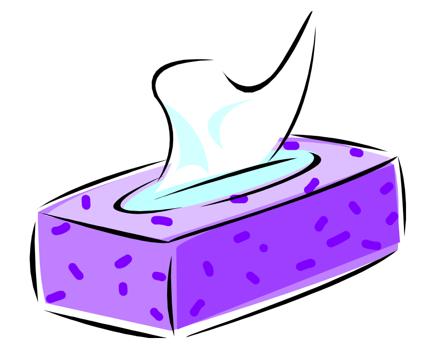
____

Staff's Signature: ____________________ **Caregiver's Signature:**_____________________

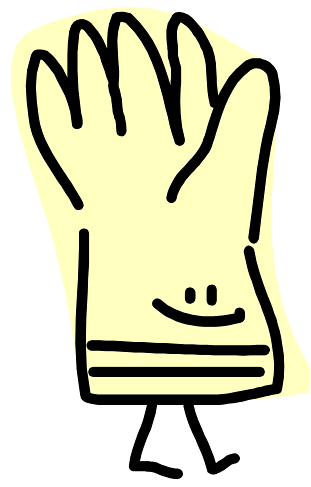
Supervisor's Signature: ____________________

UNIVERSAL PRECAUTIONS

- Wash hands
- Use non-latex gloves
- Use Hand Sanitizer/Antibacterial Gel
- Use Lysol/Clorox Wipes to disinfect



EMERGENCY BAG



INFORM STAFF

- Maintain staff:
  - Informed of all campers medical needs
  - Informed of any changes to campers medical needs or situation
  - With copies of all Emergency Action Plans signed by the parent to be kept in the Emergency Bag

ADMINISTERING MEDICINE

- Staff can not administer any medicine without consent from the parent/caregiver!!!
  - This includes TYLENOL
- Ask a local EMT/Paramedic from a local fire department to conduct an inservice for your staff on administration of medicines and basic protocols for emergencies and health concerns
- Parent should demonstrate how to use medication provided for camper

MISCONCEPTIONS

- Seizures – do not place anything in the mouth
- Fevers – if a child/youth has a fever, place cold packs on the side of the neck and at the armpits…best location to bring down the temperature

STAFF TRAINING

- Staff needs to receive proper orientation on all of the previously mentioned areas in order to be effective and well informed prior to camp beginning

Resources

- FARE – Food Allergy Research & Education www.foodallergy.com
- The Food Allergy and Anaphylaxis Network
- Emergency First Aid for Anaphylaxis – The Children's Trust website
- www.asthma.com
- www.epilepsy.com Epilepsy Foundation
- www.epipen.com

BE SAFE AND HAVE A FUN FILLED CAMP!