DIABETES CARE PLAN

This form is to be completed & signed by both parent & health care provider and should be reviewed with necessary camp and/or after school staff prior to the child starting the program. A copy is to be kept in child's file folder at program site listed below.

Child's name (printed): _____ Program Attending: _____
Child's DOB: _____ Age: _____ Grade: _____

CONTACT INFORMATION

Parent/guardian #1: (please print) _____
Phone: Home _____ Work: _____ Cell: _____
Full Address: _____
Parent/guardian #2: (please print) _____
Phone: Home _____ Work: _____ Cell: _____
Full Address: _____
Child's Doctor/Health Care Provider: _____
Health Care Provider Office Phone: _____
Nurse Educator Name: _____ Phone: _____
Emergency Contact Name (please print) _____ Relationship to child: _____
Phone: Home _____ Work: _____ Cell: _____
Notify parent/guardian in the following situations: _____
_____
_____

BLOOD GLUCOSE MONITORING

Target range for blood glucose: _____mg/dl to _____mg/dl
Type of glucose meter student uses: _____
Usual times to test blood glucose: _____
_____

Times to do extra tests (check all that apply):

____ Before exercise ____ When child exhibits symptoms of hyperglycemia ____ Before indoor gym/outdoor play
____ After exercise ____ When student exhibits symptoms of hypoglycemia ____ After indoor gym/outdoor play
____ Other (explain): _____

Can child perform own blood glucose test? ___Yes ___No Exceptions: _____

INSULIN

Times, types, and dosages of insulin injections to be given during **SUMMER CAMP program hours ONLY**:

Time	Type(s)	Dosages

Can child give own injections? ___Yes ___No
Can child determine correct amount of insulin? ___Yes ___No
Can child draw correct dose of insulin? ___Yes ___No
For children with Insulin Pumps:
Type of pump: _____
Insulin/carbohydrate ratio: _____
Correction factor: _____
Is child competent regarding pump? ___Yes ___No
Can child effectively troubleshoot problems (e.g., ketosis, pump malfunction, pump coming dislodged from the insertion point)? ___Yes ___No
Comments: _____
_____

MEALS & SNACKS EATEN DURING PROGRAM HOURS

	Suggested Time to Eat	Food content/amount
Breakfast		
A.M. Snack		
Lunch		
P.M. Snack		

Snack before exercise? ___Yes ___No If yes, list snack here: _____
Snack after exercise? ___Yes ___No If yes, list snack here: _____
Other times to give snack & content/amount: _____
_____
_____
A source of glucose, such as _____ should be readily available at all times.
Preferred snack foods: _____
Foods to avoid, if any: _____
Instructions for when food is provided to the class, e.g., as part of a class party: _____
_____
_____

Hypoglycemia (Low Blood Sugar)
Usual symptoms of hypoglycemia for child: _____
_____
Treatment of hypoglycemia for child: _____
_____

Hyperglycemia (High Blood Sugar)
Usual symptoms of hypoglycemia for child: _____
_____
Treatment of hypoglycemia for child: _____
_____
Circumstances when urine or blood ketones should be tested: _____
_____
Treatment for ketones: _____

- ➔ ***Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If required, glucagon should be administered promptly and then 911 and parents should be called. Parent to provide program staff the glucagon. Location staff will store it: _____***

PLAY, EXERCISE AND SPORTS

A snack such as _____ should be readily available at the site for instances of play, exercise and sports.
Restrictions on activities, if any: _____
_____
Child should NOT play or exercise if blood glucose is below _____ mg/dl.

SUPPLIES AND PERSONNEL

Location of supplies: *(PARENT AND PROGRAM DIRECTOR TO DISCUSS THIS SECTION TOGETHER)*

Blood glucose monitoring equipment: _____
Insulin administration supplies: _____
Glucagon emergency kit: _____
Ketone testing supplies: _____
Snack foods: _____

Prior to child's start in the program, please list below ALL camp or after school personnel that parent/guardian has reviewed the symptoms & treatment of low & high blood sugar and all additional information included in this Diabetes Care Plan, including how to use child's epi-pen if one is required. Include dates when parent reviewed with our program staff. This form MUST stay with child's registration file folder.

Staff (print name)	Staff Signature	Parent/guardian Signature	Date Care Plan was Reviewed

SIGNATURES

Pages 1-2 Reviewed by: _____ Date: _____
(child's health care provider signature)

Acknowledged/received by: _____ Date: _____
(parent/guardian signature)

Acknowledged/received by: _____ Date: _____
(program director of child care)

MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
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-adminster 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, homeophathic, 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			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

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

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

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			Emergency Medication: ☐ Yes ☐ No Known side effects:				
3						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
4						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
5						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
6						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
7						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
8						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
9						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
10						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
11						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
12						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				
13						☐ Yes ☐ No	☐ Yes ☐ No ☐ Not emergency med
			Emergency Medication: ☐ Yes ☐ No Known side effects:				

4. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)			5b. DATE (mm/dd/yyyy)

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