Healthcare Standing Orders/Protocols

Alliance for Camp Health Disclaimer: This information is provided for the sole purpose of guidance and support as a camp creates their own standing orders and guidelines. For camps or organizations who use this template, Alliance for Camp Health (ACH) is in no way responsible or liable for decisions made regarding healthcare practices and decisions at different camps and in different states. It is the responsibility of a camp to create their own standing orders/medical protocols and have them reviewed and signed by a prescriber allowed by law in that state. It is the responsibility of a camp to know the state regulations which impact their camp health services and establish orders and protocols in relation to the state law.

NOTE: This information in this document is being used with the permission of the leadership of the Alliance for Camp Health (ACH). The contents have been modified from the original template to align with the staffing model and inventory of supplies/medications at Camp Rising Sun.

EMT scope of practice and physician backup/contact protocol

The guiding philosophy of approach for using the condition-specific information included in this document is for the EMT providers making assessments and providing initial care to affected individuals to be aware of their own capabilities in the context of their scope of practice and stay within those clearly defined boundaries. If, at any time, there is a question, concern or doubt about how to proceed there should be a low threshold for contacting a physician (or an advanced practice provider, such as a Nurse Practitioner or a Physician's Assistant), either locally (e.g., at an Urgent Care facility or an Emergency Department) and/or by contacting the designated physician on call for the LAJF/CRS Health and Safety Committee.

TABLE OF CONTENTS

Standing Medical Orders

Standing orders are designed to present a coordinated approach to common camp medical problems, and to serve as guidelines for direction of the staff on duty in keeping with stated medical policies.

ROUTINE CONTINUING MEDICATIONS

1. Daily medication is typically given at breakfast;
2. Twice daily medication will typically be given at breakfast and dinner;
3. Three times a day medication will typically be given at breakfast, lunch, and bedtime;
4. Four times a day medication will typically be given at breakfast, lunch, dinner, and bedtime.

ALLERGIC REACTIONS

Anaphylaxis or allergic reaction may be associated with bee stings, insect bites, contact with or ingestion of any substance an individual may be allergic to (To include animals, plants, medications or foods). The allergic reaction may be limited to hives (urticaria) or allergic dermatitis or may be present as an immediate severe reaction compromising respiratory status. If respiratory status is compromised, a true emergency exists, and intervention must be immediate.

Assessment:

1. Respiratory status- especially hoarseness, wheezing or upper airway noises
2. Vital signs
3. Level of consciousness
4. Skin: generalized itching, flushing, hives or rash
5. Difficulty breathing? Chest tightness?
6. GI symptoms?
7. Known allergies; exposure to allergen?
8. Edema: generalized or local, especially lips, tongue, uvula, face, difficulty swallowing
9. Vomiting?

Initial Care:

Severe/ Systemic Reaction:

1. Administer epinephrine (1:1000)
    a. in a dose of 0.01ml/kg SQ to a maximum dose of 0.3ml or via auto-inject. (Repeat epi in 5-10 minutes if no response). Use auto-inject Junior if <66 pounds
    b. Or 0.2 mg Neffy epinephrine nasal spray for a >33 kg individual
2. Administer Loratadine 10 mg.
3. Alternative to Loratadine: administer diphenhydramine 25-50 mg orally, as follows:
    - 12.5 mg (25-49 pounds)
    - 25 mg (50-99 pounds)
    - 50 mg (>100 pounds)
4. Monitor vital signs every 5-10 minutes
5. Call 911 as necessary

Mild or Moderate Reaction

Any evidence of visceral involvement (wheeze, tight throat, cough, abdominal cramping)

1. Administer epinephrine (1:1000) in a dose of 0.01mg/kg SQ to a maximum dose of 0.3 ml or via Epi-pen, (Epi-pen Junior for <66 pounds.)
2. Administer Loratadine 10 mg.
3. Alternative to Loratadine: administer diphenhydramine orally, as follows:
   - 12.5 mg (25-49 pounds)
   - 25 mg (50-99 pounds)
   - 50 mg (>100 pounds)
4. If symptoms worsen, repeat epinephrine in 5-10 minutes
5. Call 911 as necessary

Mild reaction (Rhinitis, sneezing, itchy eyes without asthma episode)

1. Administer Loratadine 10 mg.
2. Alternative to Loratadine: administer diphenhydramine orally, as follows:
   - 12.5 mg (25-49 pounds)
   - 25 mg (50-99 pounds)
   - 50 mg (>100 pounds)

   OR
   - Other PRN antihistamine (cetirizine, loratadine) prescribed by medical advisor
2. Observe the individual for 30 minutes after PRN antihistamine is given
3. When condition has improved:
   - Assess precipitating factors and advise to avoid any further exposure
   - Plan for follow up observation and treatment
   - Consult MD/NP about the need for further antihistamine therapy to be given on a regular basis for the remainder of camp

ASTHMA

If a camper/individual known to have asthma is experiencing an asthma attack (exacerbation) then they should be administered the medication prescribed to them. If needed, the 'stocked' inhalers (Albuterol or DuoNeb) can be used as directed.

BITES

ANIMAL/HUMAN

Assessment

1. Vital signs
2. Identity of biting animal/person
3. Location of bite?
4. Appearance of bite (teeth marks, crushing, torn flesh)
5. Severity of the wound: location, depth, amount of contamination

Initial Care

1. Encourage bleeding

2. Using gloves, wash the area with soap and water, apply a sterile dressing
3. Verify date of recent tetanus booster
4. Determine rabies status (or the potential of the animal carrying rabies) and consult with MD/NP
5. Notify maintenance if animal is wild or identified as positive for carrying rabies
6. Notify camp administration of the bite, so they can follow County and/or State regulations for informing the local health department about an animal bite
7. Consult Physician (PA or Nurse Practitioner) on all bites for possible prophylactic antibiotic therapy
8. Strict follow up care is important:
    - Cleanse wound 3 x/day thoroughly with water
    - Observe for signs of infection: redness, swelling, warmth, increased pain, red streaks from bite, fever, discharge at wound site. Consult MD/NP if there are any signs of infection

INSECT/SPIDER BITES

Insect bites and stings are common causes of skin lesions. Insects that commonly bite and sting include: wasps, bees, mosquitoes, and spiders. Reactions vary from mild local reactions to severe anaphylactic reactions.

Assessment

1. Assess site of sting/bite for redness, swelling, itching (pictures can be helpful)
2. Revisit history of allergic reactions to offending insect or spider
3. Respiratory assessment of breathing concerns present

Initial Care

Wash the area with soap and water.

1. Apply hydrocortisone cream to the affected site
2. If rash is present, have child evaluated by the MD/NP
3. May give Loratadine 10 mg.
4. Alternative to Loratadine: may give diphenhydramine orally, as follows:
    - 12.5 mg (25-49 pounds)
    - 25 mg (50-99 pounds)
    - 50 mg (>100 pounds)

**Inform counselor of potential drowsiness if diphenhydramine is given.*

STINGS (bees, yellow jacket, wasp or hornet)

Initial Care

1. Remove stinger by outward scraping motion (squeezing causes release of more venom)
2. Apply ice or cold compress to the area of injury
3. Apply one of the following to the area: Tums (moisten TUMS, and apply to the sting site for 20 minutes) meat tenderizer, baking soda, or topical hydrocortisone (TUMS or meat tenderizer will help draw the venom out of the sting site, reducing the inflammation of the sting site)
4. If history of allergic reaction to bee stings, follow protocol for allergic reactions
5. Monitor the site

NOTE: *Children with known anaphylactic reactions to bee stings will carry or have the counselor carry their own Epi-Pens with them AT ALL TIMES. (Consult with parents before camp as to the parent preference of the camper carrying the epi, or the counselor who is with the camper carrying the epi)*

SNAKE BITES

Know the types of snakes around the camp, and in areas where campers / staff may be located.

Assessment

1. Are fang marks present?
2. Is there swelling, pain, bruising or blister formation (may take 6-36 hours to develop)
3. Vital Signs
4. Any numbness? swollen lymph nodes?
5. Any nausea / vomiting?
6. Identity of snake (if possible)
7. Location of bite?

Initial Care

1. Envenomation (i.e., snake introducing venom into the person) is not a given in a snakebite
2. Immobilize the limb: Avoid compression or constriction
3. Call 911, or transport to elevated care
4. Wash the wound, and cover with a sterile dressing
5. Consider analgesics, but avoid aspirin due to ani-coagulation concerns
6. Tourniquets are not recommended

TICKS

Ticks are vectors for numerous diseases. The tick-borne illness found in North America are Rocky Mountain Spotted Fever (rickettsial), Colorado Tick Fever (viral), Lyme Disease (bacterial) and Tularemia (bacterial)

Assessment

1. Assess site for redness, swelling (pictures can be helpful)
2. Assess the tick for fullness from feeding.
3. Fever? Muscle aches?
4. Rash (Erythema Migrans)?
5. Fatigue? Joint pain?

Initial Care

1. Perform tick checks twice daily when adventuring in tick country.
2. Gently remove tick by grasping with tweezers (or tick removal device) where tick mouthparts enter skin, using steady, gentle in-line traction
3. Place tick in a sealed container if possible
4. Cleanse area with soap and water
5. Monitor the tick site for signs and symptoms of infection
6. If evidence of infection; or if fever, rash or flu-like symptoms develop; or if circumstances support possible prophylactic treatment with an antibiotic (doxycycline) then refer to Urgent Care/ED for evaluation by MD/NP
8. Document date and location of tick in child's camp record
9. Notify parents of tick exposure and instruct them to follow up with MD/NP if fever, rash or flu-like symptoms develop

BURNS

Assessment:

1. Vital signs
2. Respiratory status
3. Agent causing the burn?
4. Time lapsed since the burn?
5. Length of time skin was in contact with burn agent?
6. Appearance of skin: reddened, blistered, charred or white
7. Depth of burn: partial or full thickness
8. Evidence of respiratory burns: soot/erythema of mouth, singed nasal hairs, cough, respiratory distress

Initial Care:

1. Remove agent causing burn if possible
2. If a chemical burn: flush with copious amounts of cool water for 20 minutes
3. Do not pull off clothing that is adhering to skin

Superficial Burns

1. Cleanse area with cool, water, rinse, and pat dry
2. Apply cool compress over area to reduce swelling and skin damage
3. Apply topical burn cream, if available
4. Consider pain medications – contact prescriber for order.
5. NSAIDs are recommended. Follow standard dosing instructions on bottle.
6. Monitor site
7. Consider MD/NP evaluation for pain management, or if a large area is burned

Partial Thickness Burns: (Red, Painful, Swollen, Blistered)

1. Cleanse area with cool, soapy water, leave blisters intact
2. Apply sterile dressing with topical burn cream, if available
3. Apply dry dressings for extensive burns; moist dressings for smaller burns for patient comfort)
4. Give analgesics, if necessary. Follow standard dosing instructions
5. Instruct patient to keep area clean and dry, leaving dressing intact
6. Medical staff will assess, clean, and redress burn daily while at camp
7. Hydrate
8. Monitor site
9. MD/NP evaluation as necessary

Full Thickness Burns (Painless, without blisters, can be pale or charred)

1. If not charred, soak in cool, soapy water
2. Consult an MD/NP immediately
3. If charred, cover with thick, sterile dressing. ***Do not remove charred clothing***
4. Transport to a medical facility

MD/NP Evaluation

1. Burns cover more than 10% of total body surface area
2. If there are partial or full thickness burns on the hands, face, feet, armpits or groin

3. Any circumferential burns
4. Any patient with signs and symptoms of airway burns

CONSTIPATION/DIARRHEA

CONSTIPATION

1. Encourage increased fluid intake, especially fruit juices
2. Milk of Magnesia or Miralax may be given as directed on bottle
3. Provide campers time and privacy as needed for restroom

DIARRHEA

Isolated cases of diarrhea are usually not serious. Usually, it will be self-limiting and will be resolved within 24 hours. Fluid replacement is important. Diet restriction is helpful, especially limiting milk, dairy, cheese, yogurt and ice cream. If diarrhea persists beyond two days or is accompanied by high fever, blood and/or mucous in the stool, consult a medical practitioner.

For troublesome diarrhea that has persisted less than 24 hours Loperamide may be used. Consult dosage on the bottle for appropriate adult and child dosages.

Diarrhea occurring among several people within hours of each other may indicate contaminated food or water sources. Should this occur, notify the director, or camp administration. Officials at the Health department may be contacted as a resource should the problem affect a large number of people, or should the problem persist.

Assessment:

1. Observe for dehydration
2. Review diet and meds taken for possible cause
3. If patient is immunosuppressed or has a history of Cryptosporidium infections, a stool sample will be needed - in this case refer to Urgent Care/ED for evaluation
4. If patient tests positive for Cryptosporidium, he/she CANNOT go in pool and an antibiotic should be prescribed - in this case refer to Urgent Care/ED for treatment
5. Pool staff will need to be notified and water checked before pool is used again.

Initial Care:

1. Encourage fluids
2. Recommended non-prescription drug therapy for diarrhea-if no response to supportive therapy
    a. Kaopectate/Pepto Bismol (liquid bismuth) 15 ml q 1 hr prn (9-12y); 10 ml q 1 hr prn (6-9y)
3. If diarrhea persists, Consult an MD/NP

DRUG OVERDOSE

NARCAN (Naloxone) - Follow the package directions for usage.

https://www.dhs.state.il.us/OneNetLibrary/27896/documents/19DOPP/NARCAN-Quick-Start-Guide.pdf

NAUSEA AND VOMITING

Common causes include viral infections, food poisoning, motion sickness, medications, indigestion, constipation, and psychogenic.

Assessment

1. Vital Signs (to include pulse, respiration and temperature)
2. Did anything precipitate the N/ V?
3. Does anything make it better? Worse?
4. Bowel sounds - normal, hyperactive or absent?
5. Time of Onset? Duration of N/V?

Initial Care:

If afebrile, with normal bowel sounds, pulse and respirations:

1. Supportive Therapy: should be the initial treatment management
    a. Dietary guidelines as appropriate for treatment of nausea, vomiting, diarrhea
    b. Keep well hydrated. If IV of NS fluid resuscitation, needed then refer to Urgent Care/ED.
    c. Clear liquids and advance to regular as tolerated
    d. Kaopectate/Pepto Bismol (liquid bismuth) 15 ml q 1 hr prn (9-12y); 10 ml q 1 hr prn (6-9y)
    e. If antiemetic is needed, consult MD/NP
2. If febrile, have the patient evaluated by MD/NP

ABDOMINAL PAIN

Send to Urgent Care/ED for evaluation if any of the following present:

- If associated with fever, vomiting
- Pain is moderate or severe
- Unable tolerate fluids
- Continuous abdominal pain greater than 2 hours
- If history of, or current testicular pain, notify physician immediately
- If any concern for ovarian or testicular torsion, notify physician immediately
- Urinary pain

UPPER RESPIRATORY ILLNESS

HEAD COLD OR NASAL CONGESTION

An acute, mild and self-limiting syndrome caused by a viral infection of the upper respiratory tract mucosa.

Assessment

1. Vital signs including temperature
2. Presence of cough, congestion
3. Status of sleep, appetite, level of fatigue
4. Duration of symptoms

Initial Care

1. May give over the counter decongestants
    a. Guaifenesin (Mucinex, Robitussin) 600-1200 mg q 12 hours > 12 years old
    B. Guaifenesin Children's Formula: 6 Years -11 Years: 10 ml every 4 hours 2.

Encourage fluids

3. Monitor temperature, if over 101.5º F or symptoms persist for over 24 hours, consult MD/NP

SINUSITIS

Assessment

1. Assess for headache, severe pain and tenderness over sinuses, and yellow green nasal drainage.
2. Duration of symptoms
3. Status of appetite and sleep

Initial Care

1. OTC decongestant
2. Hydration
3. Consult MD/NP
4. Administer decongestant and antibiotics such as prescribed by local MD/NP at Urgent Care/ED after evaluation.

SORE THROAT

Assessment

1. Visualize pharynx (redness, white spots, red spots)?
2. Pain with swallowing? Appetite?
3. Other respiratory symptoms? Cough? Congestion?
4. Vital signs to include temperature

Initial Care

1. *If febrile*, temperature over 100.4ºF, have patient evaluated by an MD/NP
2. Administer antipyretic and initiate prescribed MD/NP orders, if applicable
3. *If afebrile*, temperature 99ºF or below, have child gargle with salt water (1/2 tsp salt to 8 oz warm water), over the counter analgesics as directed by the camp prescriber (MD/NP)

EYE CONDITIONS

Assessment

1. Redness, pain, drainage? pruritus (itching)?
2. Recent trauma?
3. History of allergies?
4. Other respiratory symptoms? Cough? Congestion?
5. Lymph nodes?

Initial Care for Eye Injury

1. If chemical or foreign body has entered the eye, irrigate eye with large amounts of water or normal saline for 5-10 minutes
2. Have child evaluated by an MD/NP, if appropriate

FOREIGN BODY

Usually, a sudden onset of pain or discomfort to a single eye. Assess for obvious foreign body under lid or cornea. May try to remove if not in visual axis. Should see physician (nurse practitioner or PA) or eye specialist at the first opportunity. Should there be a small foreign body in the eye: examine the eye carefully to locate the irritating object.

Remove it with a swab or flush the eye with saline. Have a physician/NP/ PA examine the person if foreign body cannot be easily removed. The persistent sensation of a foreign body in the eye may indicate corneal abrasion,

and require exam by MD/NP, or ophthalmologist.

EYELID OR GLOBAL LACERATION

MEDICAL EMERGENCY. This may clearly present as a cut on the lid or eyeball itself, or it may present as a dark red subconjunctival hemorrhage or an eye that no longer appears round

1. Refer to an ophthalmologist immediately in the emergency department, clinic or hospital
2. Place a metal or plastic eye shield over the eye with tape for transport
3. DO NOT apply pressure to the eye or instill any medications as this may cause damage to the retina or ocular contents

CONJUNCTIVITIS

If a camper/staff member complains of painful, red, watery eyes first inquire about the possibility of foreign material in the eye, as a corneal abrasion may initially present like conjunctivitis. Contact lenses should be removed. Eye make-up should be removed, and not reapplied until the situation resolves. Assess for allergies. Red eyes with no discharge may be due to viral conjunctivitis. The condition may last 4 to 7 days.

To distinguish conjunctivitis from other conditions causing red eyes:

1. **Conjunctivitis**-redness of the conjunctiva is diffuse, pain is minimal, vision, PERRLA, contact lenses may be affected
2. **Iritis** presents with pain, moderately decreased vision, dull and swollen iris, and sluggishly reactive pupil: injection is bulbar near limbus
3. **Blepharitis** may have similar presentation as conjunctivitis with burning and itching of the conjunctiva, there is inflammation of the eyelid
4. **Corneal abrasions** often have a history of trauma with mild to moderate bulbar injection 5. **Allergies**-redness is diffuse, both eyes will be affected, also complains of “itchy eyes”; may also present with rhinorrhea, sneezing, and other symptoms of allergies

Bacterial conjunctivitis

1. Acute onset of mucopurulent discharge and sensation of foreign body in eye
2. Eyelids may be edematous with matting of eyelashes upon awakening
3. Inflammation more prominent in palpebral conjunctiva than bulbar conjunctiva
4. Typically begins in one eye and then becomes bilateral

<u>Initial Care</u>

1. Warm compresses may be helpful. Do not cross-contaminate. Use different washcloths for each eye. Special care must be taken with cleanliness and material disposal to prevent infection to other campers and staff.
2. If topical antibiotic may be needed (drops/ointment) then should be evaluated at Urgent Care/ED. Erythromycin Ointment, Polytrim or Gentamycin Drops as directed by MD/PA/NP prescriber.

Allergic conjunctivitis

1. Characterized by itchy, red eyes and rhinorrhea
2. Discharge is watery and bilateral
3. Eyelids may have “cobblestone” appearance

<u>Initial Care</u>

1. Cool compresses may be helpful and soothing
2. If topical drops or other treatment needed then should be evaluated at Urgent Care/ED.

***Contact Lens conjunctivitis*:**

1. Remove contact lenses until eyes have cleared, recommend a new pair.

Viral due to adenovirus

1. Often accompanied with a systemic infection.
2. Characterized by marked conjunctival injection, large preauricular nodes, and watery discharge

Initial Care
Usually self-limiting and may require only symptomatic treatment such as warm compresses

Viral due to herpes simplex

1. Often accompanied by fever blister on lip or face.
2. Typically, presents with vesicles on the skin of the eyelids and /or corneal herpes lesions

Initial Care
Immediate referral to ophthalmologist

CORNEAL ABRASION

Common symptoms include: pain, reduced visual acuity, lacrimation, photophobia, and foreign body sensation. Corneal abrasions usually heal within 48 hours, however, a goal of treatment is to prevent infection.

Initial Care
1. The affected eye should be treated with antibiotic drops for 5 days, checking the eye frequently during healing for the potential development of a corneal ulcer. Antibiotic drops to be ordered by NP/MD. 2. Refer to an ophthalmologist if an ulcer develops, if the child continues to complain of pain, or if the eye remains red.

CORNEAL ULCER

A white speck will be visible on the cornea and conjunctival erythema will be present. The eye will feel sore. This problem is especially common with contact lens wearers.

Initial Care
1. Refer to an ophthalmologist.

HYPHEMA (accumulation of blood between the cornea and iris - the front chamber of the eye)

The patient usually reports an antecedent injury. Blood can be seen behind the cornea and in front of the iris. Vision may or may not be affected.

Initial Care
1. Refer to an ophthalmologist
2. Keep the patient quiet with the head elevated
3. Give no aspirin or NSAIDS.

***NOTE:** This constitutes a **MEDICAL EMERGENCY** in Sickle Cell Disease*

EYE - ***CHEMICAL BURNS***

Medical Emergency

Initial Care

1. CONTINUALLY FLUSH EYE WITH WATER
2. Identify, if possible, the name of the chemical and consult MD/NP immediately
3. Call ER to notify them of transport or call 911

EARS

EARACHE

Assessment

1. Assess temperature
2. Assess tenderness on external ear by pressing on tragus, which may indicate swimmer's ear
3. Assess tympanic membrane if possible
4. Assess for other respiratory symptoms – cough? congestion?
5. Have child evaluated by MD/NP

Initial Care

1. Give analgesic/antipyretic as directed
2. Instruct child to avoid swimming, as indicated by assessment
3. If needed have evaluated at Urgent Care/ED and then give antibiotics per MD/NP order

LIVE BUG IN EAR

Send individual to Urgent Care/ED for evaluation/management

FAINTING

Individuals faint (syncopal events) for a variety of reasons – overheat, illness, poor intake, locking knees when standing, anxiety, and more. If someone has a syncopal event:

Assessment

1. Check for breathing. If no breath, initial rescue breathing or CPR
2. Heat status?
3. Vital signs
4. History of recent activities prior to fainting?
5. Food and fluid intake?
6. History of syncope?

Initial Care

1. Carefully position on back, elevate legs, assess for other injuries
2. Attempt to arouse child with gentle patting or cool compresses
3. Hydrate once individual is conscious and aware (if needed)
4. Have child evaluated by an MD/NP, if appropriate

FRACTURES/SPRAINS/STRAINS

Assessment:

1. Vital signs
2. Appearance of injury: obvious deformity, swelling, ecchymosis, pain, dislocation, tenderness, crepitus, loss of function, limited motion, guarding
3. Quality of pulses and sensation distal to the injury
4. Immediate nausea at the time of injury may indicate fracture.
5. Mechanism of injury
6. History of trauma
7. Time of injury

Initial Care If due to a specific injury:

1. Immobilize the injury as found. Immobilize the joints above and below the injury as possible.
2. Recheck pulses
3. Sterile dressing to open fractures
4. Ice to the injured site (barrier between ice and skin)
5. Monitor pulses distal to the injury
6. Monitor vital signs and treat for shock as necessary
7. Transport patient to medical facility for x-ray and elevated care

**** If pulses distal to the injury are absent, the injury is a medical emergency and must be splinted and transported to a medical facility without delay***

1. Notify parents, then update with the results of ER visit and follow-up plan
2. Complete appropriate documentation

Non-deformed musculoskeletal injuries may be splinted, elevated and observed. They may be taken for evaluation at a later time, if the injury is well tolerated, and parent/guardians are consulted

If due to non-specific complaint:

1. Assess affected extremity as above
2. If no obvious injury, consider homesickness and/or seeking adult attention

****NOTE:** Ace wraps, slings, crutches, etc. are "valued" attention seeking devices and should be used with discretion.*

BACK STRAIN

1. Limited bed rest with application of ice.
2. Ibuprofen as needed.
3. If necessary, educate about proper lifting techniques.

FEVER

Fever is a symptom, not a disease. Fever is the body's normal response to infections and helps in fighting them. The usual fevers that children get (100º-104ºF) are usually not harmful. Most are due to viral illnesses, some are due to bacterial illnesses. Most fevers associated with viral illnesses range between 101ºF and 104ºF, and

last for 2 to 3 days. Generally, fever causes no symptoms until it reaches 102º or 103ºF.

Children at camp may simply have elevated (low grade: 100.5º - 101º) temperatures due to dehydration and/or fatigue. A good assessment is important. Good care is vital, to support recovery. If an individual has a slightly elevated temperature, and does not appear to be ill, an amended schedule may be appropriate. Do not minimize this care, as the individual may be more susceptible to further compromise.

Assessment

1. Hydration status
2. Recent activities? Outdoors?
3. Respiratory symptoms?
4. Headache? Joint aches?

Initial Care

1. Administer acetaminophen or ibuprofen as needed until the fever goes down
2. Encourage fluids (water)
3. Attempt to determine the cause of the fever, while providing symptomatic relief
4. Have individual evaluated at Urgent Care/ED if a fever persists longer than 48 hours, or if it goes above 103ºF

In a non-immunocompromised child

1. Complete history physical assessment
2. If camper has no known risk for neutropenia may give Tylenol or Ibuprofen according to manufacturer guidelines
3. Isolate camper if infectious risk.
4. Refer to Urgent Care/ED for evaluation if indicated.

In an immunocompromised child (unknown CBC)

If an immunocompromised camper develops a fever (T>101.5º Fahrenheit) they should be evaluated as follows:

1. Consult MD/NP
2. Camper should remain in the Health Center until sent to Urgent Care/ED.

Fever with known neutropenia

If a camper with known neutropenia (ANC<500mm3) develops a significant fever (T > 101.5ºF), especially if accompanied by chills or signs of toxicity, they must be treated as if they are septic.

1. Send to Urgent Care/ED to be evaluated by MD/NP.
2. Administer antibiotics as ordered
3. Per MD/NP order, arrange transport to child's home hospital if within 1.5 hours of camp. If child is over 1.5 hours from his/her home hospital, arrange transport to the nearest children's hospital
4. Call parents and PCP
5. A nurse and/or MD/NP may accompany the child to hospital. Mode of transport will depend on the child's condition. Bring necessary documentation with transfer

Fever and Asplenia (i.e. Sickle Cell Disease)

If a camper develops a significant fever (T>101.5ºF), or lower if accompanied by chills or signs of toxicity, they must be treated as septic. Send to Urgent Care/ED to be evaluated by MD/NP

HEADACHE/HEAD INJURIES

HEADACHE

Headache may be a symptom of dehydration, fatigue, altitude illness.

Assessment

1. Assess whether there has been any trauma to the head or neck
2. Duration of headache?
3. Location and intensity of headache? Photophobia?
4. Associated nausea or vomiting?
5. History of headaches?
6. Fluid intake today? Urine output?
7. Recent activities? Heat exposure?

Initial Care

1. Hydrate
2. Allow the person to lie down and rest in cool space.
3. If a staff member, relieve them of their duties temporarily so they can rest.
4. Ibuprofen or acetaminophen according to instructions on bottle to help relieve the discomfort.
5. If severe pain, neurologic symptoms or emesis are present, send to Urgent Care/ED to be evaluated by MD/NP.

HEAD INJURIES

Any blow to the face or head, whether blunt or penetrating has the potential risk of increased intracranial pressure, or intracranial bleeding. Some individuals, after receiving a blow to the face or head are low risk, and may not need immediate medical evaluation, based on the following:

1. The injury was relatively trivial
2. Consciousness was not lost, and there was no change in level of consciousness
3. No history of a bleeding disorder, or medications which might increase the risk of bleeding
4. There is no change in vision, vital signs
5. Excessive headache or repeated emesis are not present

This person must be carefully monitored for changes, particularly to level of consciousness. Conduct concussion assessment as directed by source. (Example – Appendix C). Consult a higher level of care immediately if there is any change in level of consciousness.

For any trauma to the head or face, assume the potential for c-spine injury also, and assess and treat accordingly. If the person loses consciousness, even briefly, an exam by medical personnel is indicated.

Assessment:

1. History of injury/mechanism/force involved
2. Vital signs- especially respiratory pattern and rate; every 10 minutes for the first hour, then
3. Level of consciousness: (Glasgow coma scale for comatose patients)
4. Pupils: are they equal and reactive
5. External evidence of trauma
6. Blood or fluid from the ears or nose

7. Medical history of current medications

Initial Care:

1. Immobilize the person's head and neck if there is any indication of spine or back injury
2. Maintain patent airway (jaw lift or nasopharyngeal airway- do not move c-spine if concern for injury)
3. O_2 4-6 L/minute per mask if needed.
4. Cool compresses to the bruised/contused area. Give nothing by mouth; no sedatives.
5. Record vital signs every 10 minutes for the first hour, then hourly x4.
6. Unconscious persons must be transported without delay to the medical center.

Specific Precautions:

Restlessness may be a sign of hypoxia. If the person needs airway and ventilation support, hyperventilate the person. Inadequate ventilation (buildup of CO_2) aggravates cerebral edema.

HEAT EXHAUSTION/STROKE

HEAT EXHAUSTION

Exertional heat illness, heat exhaustion is a vague term describing an inability to cope with heat stress. A milder form of heat-related illness that can develop after several days of exposure to high temperatures and inadequate or unbalanced replacement of fluids

Assessment

1. Fatigue
2. Nausea and/or vomiting
3. Loss of appetite
4. Muscle cramps
5. Dizziness with syncope possible
6. Heart rate and respiratory rate elevated
7. Skim pale, cool and clammy or slightly flushed

Initial Care

1. Assess vital signs to include temperature
2. Remove from heat to avoid further heat stress
3. Rest in cool location
4. Hydrate, hydrate!
5. Treat muscle cramps with gentle stretching
6. Consult MD/ NP if not improving

HEAT STROKE

Heatstroke is a life threatening emergency. Patients have exaggerated heat production and an inability to cool themselves due to extreme classic heat stroke or exertion heat stroke. Altered mental status is an important distinguishing feature between heat stroke and heat exhaustion.

Assessment

1. Headache, dizziness, disorientation, agitation or confusion?
2. Sluggishness or fatigue? Seizures?
3. Hot, dry skin that is flushed but not sweaty, high body temperature?

4. Rapid heart rate?
5. Loss of consciousness?

Initial Care

1. Move indoors where it is cool
2. Remove clothing and gently apply cool water to the skin followed by fanning to stimulate sweating
3. Apply ice packs to the groin and armpits
4. Have the person lie down with their feet slightly elevated
5. Offer sport drinks, such as Gatorade, to restore body fluids, electrolytes and salt balance (only if individual is awake and alert)
6. Consult MD/NP. Intravenous fluids, administered at Urgent Care/ED, may be necessary to compensate for fluid or electrolyte loss

GENITOURINARY

GYN

- Notify a physician for any abdominal or pelvic pain that is beyond the typical menstrual pain.

UTI (suspected)

- Send to Urgent Care/ED to be evaluated by MD/NP

MENSTRUAL CRAMPS

1. Offer heating pad or warm compresses
2. Ibuprofen/ or Tylenol per bottle instructions as needed
3. Bed rest as necessary

MOTION SICKNESS

From riding in a car or being in a boat on the water, consider administering Dramamine (dimenhydrinate antihistamine) as directed.

NEAR DROWNING

1. Immediate CPR and administration of Oxygen
2. Call 911 for transport to ER

NOSEBLEED (Epistaxis)

Assessment

1. Trauma to nose or face?
2. History of epistaxis?
3. Duration of nosebleed?
4. Vital Signs
5. Assess for head injury if a result of trauma to the head or face

Initial Care

1. Pinch soft tissue of both nostrils tightly together with thumb and forefinger, pressing toward bony part of the nose

2. Sit upright with head in neutral position
3. (Forward tilt of the head increases blood flow to the area. Backward tilt of the head may cause blood to trickle down the throat causing choking or nausea)
4. Remain seated with nostrils pinched at least 5 minutes. If bleeding does not stop, repeat steps 1-3
5. Ice may be applied to cheek or face
6. Assess the cause of nosebleed. If related to injury, evaluate for further facial injury once bleeding has stopped. Consult MD/NP, as necessary
7. Instruct child to refrain from blowing nose for the next 4-6 hours
8. If bleeding persists more than 20 minutes, notify MD/NP on call

ORTHODONTICS

If wire broken or any other issue, refer to orthodontist

RASHES/SKIN IRRITATION

Assessment

1. Appearance of rash (color, lesion type, texture)
2. Local reaction or systemic reaction?
3. Recent exposures – plants, animals, chemicals, foods?
4. Pain or pruritus?
5. Does anything make the rash better or worse?
6. Had this rash previously?
7. Vital signs
8. Amount of skin surface covered by the rash

Initial Care

1. Check VS
2. Rule out contagious causes such as varicella or measles immediately
3. Isolate as necessary and consult an MD/NP
4. Reinforce hand washing with camper and counselor
5. For uncomplicated rashes (“heat” rash; chafing from friction; etc.) could use Caldescene (zinc oxide or talc drying agents, like Babt Powder))

ATOPIC DERMATITIS

1. Limit use of soap and follow bathing immediately with application of moisturizing cream
2. Hydrocortisone 1% cream or ointment may be used
3. If rash does not improve, consult an MD/NP

FUNGAL INFECTIONS

1. Keep lesions dry. Consult an MD/NP
2. Treat with Lotrimin per package instructions and check cabin mates
3. If scalp is involved consult an MD/NP for evaluation and treatment

IMPETIGO

A bacterial skin infection characterized by blisters that may itch.

1. Apply antibiotic ointment (Neosporin, Bacitracin) per package instructions to site(s)
2. Significant handwashing to prevent spread

3. The camper should be seen by an MD/NP to assess the need for antibiotics

POISON IVY, OAK OR SUMAC

1. Wash all exposed areas of skin with soap and water immediately.
2. Apply Tecnu gel to affected areas according to directions to remove urushiol oil (the plant resin involved) and for comfort
3. For itching, may give Loratadine 10 mg.
4. Alternative to Loratadine: may give diphenhydramine:
    a. Administer diphenhydramine 25-50 mg orally, as follows:
        - 12.5 mg (25-49 pounds)
        - 25 mg (50-99 pounds)
        - 50 mg (>100 pounds)
4. Consult with MD/NP as necessary
5. Administer prednisone as ordered by MD/NP.

URTICARIA (HIVES)

Urticaria is a skin rash which may result from exposure to an allergenic or non-allergenic agent. It is usually transitory but may recur over weeks or months. Urticaria may be caused by food or drug allergy, insect stings, infections, physical and psychogenic factors.

1. If at any time you feel the camper is unstable call 911 and transport to the local ER.
2. Administer Loratadine 10 mg.
3. Alternative to Loratadine: may give diphenhydramine 25-50 mg orally, as follows:
    - 12.5 mg (25-49 pounds)
    - 25 mg (50-99 pounds)
    - 50 mg (>100 pounds)

SCABIES AND LICE

1. Symptoms include: local lymphadenopathy, scratching, presences of nits or lice
2. Treat with Nix or Rid (topical lice treatment) according to package instructions.
3. Launder all clothes, hats, and linens, cleanse mattress, pillows, etc in HOT water
4. Soak combs and brushes is very hot water.
5. Check all cabin mates and close contacts.
6. Entire cabin may need sheets and clothing laundered in hot water.

SEIZURES

Assessment

1. Vital Signs
2. History of seizures
3. Head Injury/trauma?
4. Assess mental status
5. Good physical assessment to include vision changes, one sided weakness, incontinence, headache

Initial Care

1. Maintain safety
    a. Ensure area is clear of harmful objects, especially around head.
2. Place on side to maintain open airway during post-seizure recovery phase.

3. Complete assessment after the seizure to check for injuries.
4. Allow to rest and consult an MD/NP.
5. Oxygen may be required and should be brought to the scene as precaution.
6. Serum drug levels may be needed depending on patient diagnosis; if determined to be necessary individual should be sent to Urgent Care/ED.
7. For status epilepticus (any seizure lasting longer than 15 minutes) call 911 and send to Urgent Care/ED.
8. If patient has a known seizure disorder, administer seizure medication according to medication administration record (MAR).

SPLINTERS

Initial Care

1. If they can be easily removed, do so with a sterile tweezer (or 'splinter out' device). (Gloves should be worn)
2. Do not soak wood splinters as they will swell and become more difficult to remove
3. If the splinter is deep or if there is difficulty in removing it, consult an MD/NP
4. Once removed, follow the guidelines for treatment of an abrasion

SUNBURN

Assessment

1. Areas affected
2. Skin assessment (pictures helpful)
3. Known prevention activities (wearing sunscreen?)
4. 1st, 2nd, 3rd degree determination?

Initial Care

1. Apply cool compresses to affected areas
2. Consider evaluation by MD/NP
3. Administer Tylenol or ibuprofen per instructions on bottle as needed for pain
4. Avoid further sun exposure to affected area until healed
5. Loose cotton clothing is often most comfortable
6. If burns significant (2nd or 3rd degree and/or extensive areas of body) have evaluated by MD/NP

TOOTH INJURY

PRIMARY

Initial Care

1. *If knocked out or broken,* cover area with clean gauze to control bleeding as necessary
2. Have child evaluated by MD/NP if applicable

PERMANENT

Initial Care

If knocked out:

1. Find missing tooth and rinse tooth gently, taking care not to damage root
2. Rinse child's mouth and notify MD/NP

3. Reinsert tooth into socket, if possible and if trained to do so
4. If unable to reinsert tooth, place tooth in sealed container of cow's milk
5. Arrange for transport to the child's dentist or the ER as instructed by MD/NP

If chipped or broken:

1. Find missing pieces and place in sealed container, if possible
2. Cleanse area and apply ice to prevent soft tissue swelling if indicated
3. Notify MD/NP
4. Arrange for transport to a dentist

TOOTHACHE

Assessment

1. Evaluate oral cavity for redness, swelling, pain, bleeding, drainage?
2. When did toothache begin?
3. History of toothache?
4. Temperature

Initial Care

1. May treat with Tylenol or Ibuprofen per package instructions.
2. Refer to dentist as necessary

DENTAL ABSCESS

Assessment

1. Evaluate oral cavity for redness, swelling, pain, bleeding, drainage?
2. When did abscess begin?
3. Temperature

Initial Care

1. Irrigate with saline
3. Refer to dentist

GUM IRRITATION

Initial Care

1. Irrigate with saline solution or half-strength hydrogen peroxide
2. Refer to dentist if needed

WOUNDS/CUTS

Short term care for all wounds: Control bleeding
Extended Care: Prevent infection and promote healing

Assessment

1. Event leading to cut?
2. Assess pain, bleeding, depth/width? (Pictures helpful)
3. Foreign bodies?
4. Duration of time since cut?
5. S/S of infection – redness, drainage, increasing pain?
6. Immunization status?

CUTS AND SCRAPES

Initial Care

1. Control bleeding; apply direct pressure (with sterile dressing if available)
2. Wash with soap, rinse and pat dry
3. May apply antibacterial ointment three times daily. (Neosporin/Bacitracin)
4. Cover with band-aid or sterile gauze dressing
5. If unable to control bleeding, apply direct pressure to the site. *Do not use a tourniquet*
6. Consult an MD/NP if the wound:
    a. Is deep enough to require sutures or other form of closure
    b. Opens a joint space
    c. Involves underlying tendons or ligaments
    d. Has an impaled / embedded object
    e. Is heavily contaminated
    f. Was caused by a crushing mechanism
    g. Was caused by an animal bite
    h. If tetanus immunization status is not current, or is unknown

ABRASIONS

Initial Care

1. Irrigate with copious amounts of clean water
2. Clean with soap and water
3. Rinse / dry / apply antibiotic ointment (Neosporin, Bacitracin) and cover with dressing
4. Monitor the wound daily for signs of infection
5. Consult MD/NP for any signs of infection, or for abrasions covering a large surface area (for pain control and possible antibiotic therapy)

DEEP WOUND

Initial Care

1. Using gloves, apply pressure to the wound to control the bleeding
2. If the bleeding does not stop, consult an MD/NP immediately for further evaluation
3. If the wound is a puncture wound or very deep, check the camper's medical record for the date of his/her last Tetanus shot
4. Consult MD/NP with this information and send to Urgent Care/ED if directed to do so
5. If the bleeding is controlled and the wound appears clean after cleansing with soap and water, and MD/NP has completed an evaluation of the camper, follow the procedure for abrasions

BRUISE OR CONTUSIONS

Initial Care

1. Apply ice
2. Cleanse as necessary with soap and water

Appendix A: Medications

Suggested List of Stock Medications.

These are all the medications listed in these standing orders. Depending on the camp population, adult and children's strength should be stocked. If you add medications to this list, remember to add a standing order to cover the use of the medication.

Camp Medical Inventory needs to be updated to reflect only these OTC medications and not others.

Over the Counter (OTC)

Anti-fungal cream
Hydrocortisone/anti-itch cream
Diphenhydramine oral and topical
Caldesene
Milk of Magnesia
Loratadine (antihistamine)
Guaifenesin (e.g. Robitussin /Mucinex/cough syrup)
Lice/lice egg topical ointment
Neosporin or Bacitracin
Acetaminophen 250mg & 500mg (liquid and chew tabs)
Hydrogen Peroxide
Saline (for cleaning)
Zanfel or Tecnu
Oral Glucose 3

Emergency

Injectable epinephrine
Albuterol sulfate 2.5mg/3ml
Narcan

Appendix B: Health Care Supplies

Suggested List of Stock Healthcare Supplies/Equipment

Gauze (2x2, 4x4) - yes
Bandaids yes
Soap (plenty) - include
Tape (variety) yes
ACE wrap(s) - no
Coban wrap - yes
Sharps containers - no
Gloves - yes
Tweezers - yes
Splinter Outs - yes
Hemostats - yes
Cold and Hot Compresses - no
Sterile Dressing(s) - burn dressing, pressure dressing
Saline irrigation - saline solution
Vital sign equipment (Temp, BP, HR) - yes temp and BP, no HR
Splint - yes
Eye patch - eye pad yes, no eye patch
Arm sling/support - yes
Immobilizer(s) - yes several
Stethoscope - yes
Neck Brace - no
Backboard - yes
AED - yes
Scale - yes

Additional Supplies (not from ACH recommendation)
O2 Tank

Appendix C: Concussion Symptom Inventory

For an individual who experiences a head injury, consider using a tool such as this to conduct an assessment every 15-30 minutes until status is improved or the individual is transported to higher level care.

Concussion Symptom Inventory (CSI)
Randolph, Millis, Barr, McCrea, Guskiewicz, & Kelly (2008)

Player Name:_____
Date of Injury:_____ Date of Exam:_____

	absent 0	*mild* 1 2	*moderate* 3 4	*severe* 5 6	Score
Headache					
Nausea					
Balance Problems/Dizziness					
Fatigue					
Drowsiness					
Feeling like "in a fog"					
Difficulty concentrating					
Difficulty remembering					
Sensitivity to light					
Sensitivity to noise					
Blurred vision					
Feeling slowed down					
TOTAL:					

Other symptoms evident since injury?: