Summer Camp Medical Consent Packet

Important Information for Parents/Caregivers

- To ensure the health and safety of campers, complete and timely submission of medical documentation is required.
- Submit all medical documents immediately following the physical exam. Your camper's file will not be considered complete until all required documents have been submitted.
- Medical documentation must be received at least 2 weeks **prior** to your first camp session.
- **ALL** medical forms **MUST have a Physician/NP's signature on them** (this includes prescriptions and over-the-counter medications).
- **IMPORTANT medical documents included in this packet:**
  - Policies for your information and review
    - Medical Information Notice
    - Camp Baker Medication Policy
  - Required forms that must be completed and returned
    - Permission for Emergency Medical Attention
    - Consent to Exchange Information
    - Physicians Order for Medication
    - Physical Examination Form
  - Optional forms based on camper's needs
    - Physicians Order for Devices
    - Seizure Protocol
    - Diabetes Plan
    - G~~g~~-Tube Plan
- The parent/guardian/camper hereby agrees to assume financial responsibility for any and all medical expenses incurred by the camper while at SOAR365 Summer Camp which are not camp related and understands that SOAR365 is not liable for any such expenses.
  PLEASE ENSURE INSURANCE INFORMATION AND COPY OF INSURANCE CARD(S) WITH FRONT AND BACK VIEWS IS SENT WITH MEDICAL FORMS

My camper's physical exam is scheduled for:

***Annual physical exams must take place less than one year from the final day your camper is scheduled to be at camp. Physicals must be returned to Camp Baker **prior** to the camper's arrival. Camper **will not** be accepted at check in if the physical has not been received. Please understand, this gives our medical team time to review the documents and better ensure the safety of your camper.*

SOAR365

Medication Policy at Camp Baker

Please read carefully! To ensure camper safety and prevent medication errors, we have a few **requirements** that must be followed. Adhering to these guidelines will help keep check-in day fun and smooth!

1. **ALL medications require a SIGNED physician/NP order (no older than one year). This includes: over-the-counter medications, g-tube feeds/flushes, medical protocols and medical equipment.**
2. We will accept medication that are in **blister packs, pills bottles, or pharmacy packaged pill packs.** We will not accept medication that is self-sorted into a pill box. The pills must come in their original container from the pharmacy, and the **label on the container must match the physician orders for the medication. We will not accept expired medication.**
    - ***Note: Most pharmacies are able to provide medications in blister packs for the days the camper will be at camp.***

3. Please send the amount of medication the camper needs for their entire time at camp, **as well an extra 2 days of medication for emergencies** (in case of issues with pickup on Friday, tablet dropped while taking, etc.)
4.
5. Included in this packet are forms for those with g-tubes, diabetes, and seizures. Please fill these out if needed to provide more information for your camper's care at Summer Camp. **These protocols MUST be signed by camper's physician/NP and returned no later than 2 weeks prior to the camper's scheduled arrival date.**

6. **If you have any medication changes prior to your stay at Summer Camp, please have the physician/NP fax those changes to us at (804) 956-3571 as soon as possible!**

Please contact SOAR365 @ Camp Baker with any questions/concerns at:
(804) 748-4789 or summercamp@soar365.org

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Practices Effective July 1, 2014

The Health Insurance Portability & Accountability Act (HIPAA), also known as the HIPAA Privacy Rule, as well as certain provisions of Virginia law, set forth requirements for protection of health information about you. SOAR365 (formerly Greater Richmond ARC) applies the same privacy standards to all records it has that include information about you. SOAR365 is committed to keeping our participants' personal information private. This Notice of Privacy Practices explains your rights and the Agency's duties with respect to health and other information about you that is kept in the Agency's records.

SOAR365 is required by federal and state law to protect the privacy of your protected health information and other personal information, to provide you with notice about our policies and protections, **and to notify you following a breach of your unsecured protected health information**. "Protected health information" is information that is maintained or transmitted by SOAR365, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you and will use it to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it.

When we disclose medical information about you, we will attach a statement that tells the person receiving the information that they cannot disclose it to anyone else unless you give them permission or unless a law allows or requires them to disclose the information without your permission.

If you have someone making decisions on your behalf because you are not able to make decisions yourself, we will give a copy of this Notice to that person, and we will work with that person in all matters relating to uses and disclosures of your health information.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

HIPAA and Virginia law generally permit SOAR365 to use or disclose your protected health information without your permission for purposes of health care treatment, payment activities and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

- **Treatment:** When and as appropriate, we may use or disclose medical information about you to provide, coordinate, or manage your health care and any related services. For example, we may disclose to providers such as the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department for Aging and Rehabilitative Services (DARS), and community services boards (CSB) health information they may need to prescreen you for services or to prepare and carry out your individualized services or discharge plan. We may also disclose your protected health information, as necessary, to your physician or to a home health agency that provides care to you.
- **Payment:** When and as appropriate, we may use and disclose medical information about you to obtain payment for your health care services provided by us or by another provider. This may include uses and disclosures that are necessary for us to file claims with your health insurance plan. We must follow Virginia law that limits the amount of health information we can disclose about you.
- **Health Care Operations:** When and as appropriate, we may use and disclose medical information about you for the ARC's operations or the operations of another health care provider, as needed. These operations include, but are not limited to, quality assessment activities, employee review activities, licensing, human rights or certification or accreditation reviews.

OTHER PERMITTED USES AND DISCLOSURES

- **To find someone to make decisions on your behalf:** If you are not capable of making medical decisions, we may disclose your health information in order to identify someone to make those decisions for you. Before we disclose any information, we must determine that disclosure is in your best interests.
- **To Comply with Federal and State Requirements:** We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by government agencies that regulate us; to federal, state and local law enforcement officials; in response to a judicial order, a subpoena that complies with Virginia law, or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting abuse and neglect, threats to public health and safety and for national security reasons). We are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- **Health Oversight Agencies:** We may disclose your medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensing. Examples of health oversight agencies include the Office of the Inspector General, the Department of Health Office of Quality Care, the Disability Law Center of Virginia (formerly the Virginia Office for Protection and Advocacy), the Local Human Rights Committee (LHRC), and the State Human Rights Committee (SHRC).
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness, as authorized by, and to the extent we are required to do so to comply with, law.
- **Correctional Institutions and Other Law Enforcement Custodial Situations:** We may disclose medical information to a correctional institution or to certain law enforcement officials if it is necessary for your care or if the disclosure is required by state or federal law.
- **Business Associates:** We may share your protected health information with third party "business associates" that perform various activities (for example, billing services) for the SOAR365. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
- **Research:** We may disclose your protected health information to researchers when the information does not identify you or, with your consent, when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Facility Directory:** SOAR365 maintains a directory of individuals who are in our programs. We will let people know, when they call or come by and specifically ask for you by name, that you are here. You can restrict or stop this by contacting the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227.
- **Disclosure to Others Involved in Your Care:** SOAR365 may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. Usually, this will be done only if you are present and do not object. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. You may ask us at any time not to disclose information about you to persons involved in your care. We will follow your request, except in limited circumstances (such as emergencies). Our usual practice is to get your written authorization to disclose information to others.
- **Disaster Relief:** We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. We will try to get your permission before doing this.

USES AND DISCLOSURES FOR OTHER PURPOSES

SOAR365 will not use or disclose your protected health information for any purpose other than the purposes described in this Notice without your written permission. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of medical information for marketing purposes; and disclosures that are a sale of medical information. You may take back an authorization that you gave before by sending a written request to the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227, but not about any actions SOAR365 has already taken.

POLICIES ABOUT USES AND DISCLOSURES

Any time we disclose information without your permission to anyone except employees of DBHDS, a community services board or other providers, we will place in your medical record a written notation of the information we disclosed, the name of the person who received the information, the purpose of the disclosure, and the date of disclosure. We will also let you know in writing about the disclosure, including the name of each person who received the information and the nature of the information. We will do this before the disclosure or in an emergency, as soon as we can afterwards.

If the disclosure is not required by law, we will give strong consideration to any objections for you in making the decision to release information.

Before we disclose information to anyone, we will verify the identity and authority of the person receiving the information.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

RESTRICTIONS ON USES AND DISCLOSURES

You have the right to request restrictions on who can see your protected health information. While SOAR365 will consider all requests for restrictions carefully, we are not required to agree to a requested restriction, with one exception: We are required to agree to a requested

restriction of disclosure to a health plan, if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and is only about a health care item or service for which SOAR365 has been paid in full by you or someone other than the health plan. If we do agree to a restriction, we will follow the restriction unless the information is needed to provide emergency treatment.

CONFIDENTIAL COMMUNICATIONS

SOAR365 may contact you by phone, email or mail at your home and may leave messages on an answering machine or voice mail. However, you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must include how or where you wish to be contacted.

INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

You have the right to see and copy your protected health information. If you ask for copies, the SOAR365 may charge you copying and mailing costs. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will also share this medical information with a lawyer of your choice. To ask for copies or request that a denial be reviewed, contact the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227.

CORRECTING PROTECTED HEALTH INFORMATION

You have the right to make corrections to your protected health information. If your doctor or another person created the information that you want to change, you should ask that person to change the information.

We may deny your request to correct your protected health information if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to correct any of the following information:

- Information that is not part of the medical information kept by or for SOAR365.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the
- correction.
- Information that is not part of the information which you would be permitted to inspect and copy.
- Information that is accurate and complete.

If SOAR365 denies your request, you may have the denial reviewed. To request a review of a denial, contact the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227.

Whether or not we make the corrections you request, you can let anyone who sees your record know that you tried to make corrections to your record.

ACCOUNTING OF DISCLOSURES

You have the right to know who your protected health information is disclosed to. We are not required to give you information about disclosures made:

- For treatment, payment, or health care operations.
- To you or your authorized representative about your own health information.
- Incidental to other permitted disclosures.
- Where authorization was provided.
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a limited data set where the information disclosed excludes identifying information.
- Information from more than six years before the date of your request.

Information we disclose to a social service or protective service agency, if we reasonably believe you are a victim of abuse or neglect, and we believe that informing you or your authorized representative would put you at risk of serious harm; we may also choose not to inform you or your authorized representative if we believe your authorized representative is responsible for the abuse or neglect, and informing your authorized representative would not be in your best interests.

To request this list or accounting of disclosures, contact the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before there are any costs.

BREACH NOTIFICATION

We understand that medical information about you and your health is personal, and we are committed to protecting your medical information. Furthermore, we will notify you following the discovery of any "breach" of your unsecured protected health information as

defined in HIPAA, as required by law.

COPIES OF THIS NOTICE

You have the right to a paper copy of this Notice, even if you received this Notice electronically. You may contact the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227, to get a paper copy of this Notice.

QUESTIONS OR COMPLAINTS

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that SOAR365 has not respected your privacy rights, or disagree with a decision that SOAR365 made about who can see your protected health information, you may contact the Vice President of Human Resources, SOAR365, 3600 Saunders Ave., Richmond, VA 23227, to discuss the situation or file a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to the Secretary, Office for Civil Rights, U.S. Dept. of Health & Human Services, 200 Independence Ave, SW, Washington, D.C. 20201. We will not take any action against you if you file a complaint with the Secretary of Health and Human Services or the Vice President of Human Resources.

CHANGES TO THIS NOTICE

SOAR365 may change this Notice at any time. If the Notice is changed, SOAR365 may make the new Notice effective for all of your protected health information that SOAR365 maintains, including any information created or received before the new Notice. If SOAR365 changes this Notice, you will be notified of the change.

SOAR365

Physical Examination

Camper's Name: _____ DOB: _____ Gender: _____

Height: _____ Weight: _____ Temp: _____ HR: _____ RESP: _____ BP: _____/_____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Other Medical Conditions: _____

Communicable Diseases

Is this person free from communicable TB and any other airborne communicable diseases? ☐ Yes ☐ No

Which tests or screenings were done to verify the individual is free from active TB?

Screening Only ☐ (Free of symptoms)

Blood Test: Date: _____ Results: _____

PPD:

Chest X-Ray (if PPD positive or unable to administer PPD):

Date: _____ Results: _____ mm

Date: _____ Results: _____

Current Medications and Treatments (Include dosage and time taken):

Is this person capable of administering his/her own medication? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No

If yes, note reaction and treatment: _____

Restrictions and Recommendations

Instructional Activity:

Physical Activity:

Community Outings:

Dietary Restrictions:

In my opinion the above-mentioned individual ☐ CAN ☐ CANNOT participate in SOAR365 programs.

To the best of my knowledge all information concerning above named individual is correct, and no information has been withheld from SOAR365 regarding the Individual's disability, history, behavior, skills, or communicable diseases.

*PCP Signature: _____ Date of Examination: _____

PCP Name: _____ Phone Number: _____ Fax: _____

Address: _____

SOAR365

Permission for Emergency Medical Attention

I, as ☐ Self ☐ Legal Guardian or ☐ Authorized Representative, hereby give my permission for SOAR365 to secure emergency medical attention for:

Camper's Name: _____

Insurance Company Name: _____

Insurance Policy Number: _____ Medicare or Medicaid Number: _____

☐ Camper is able to communicate verbally without assistance.
If not checked describe other means (if any): _____

☐ Camper has an Advance Directive. If checked specify: _____

Physician

In the event of injury or illness while in the association's care, I request the following be called first. I understand that if he/she is not available another doctor will be called, and I will be notified as soon as possible.

Doctor's Name: _____ Email Address: _____

Phone #: _____ Address: _____
Street City State Zip

Emergency Contacts

If I am not immediately available, please notify:

Contact 1 Name: _____ Relationship: _____

Phone #: _____ Address: _____
Street City State Zip

Contact 2 Name: _____ Relationship: _____

Phone #: _____ Address: _____
Street City State Zip

Permissions and Responsibilities:

☐ I give permission to SOAR365 to transport the camper for the purpose of receiving emergency medical treatment.
☐ I will be solely responsible for any emergency medical treatment given to the camper.
☐ I will be solely liable for all expenses incurred for emergency medical treatment to the camper.

SOAR365 accepts no responsibility for ordering emergency medical treatment and neither the SOAR365 nor any of its agents or employees has any liability in this regard.

This consent is good until: ☐ My service case is closed OR ☐ Until (date): _____

Name: _____

Signature: _____ Date: _____

Day Phone: _____ Mobile: _____ Evening: _____

Rev 1.2026

SOAR365

Physician's Order for Medication

Medication Prescribed To: _____ Date of Birth: _____

Each page needs to have ihe camper's name and a physician/NP signature to be accepted.
If more space is needed for scheduled medications, please print additional copies of this first page.

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	

Physician/NP Signature: _____ Date: _____

SOAR365

Physician's Order for Medication

Medication Prescribed To: _____

PRN Medications (see next page for OTC PRNs)**:**

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	
What is the PRN specifically for?	

Medication Name/Concentration:	
Dosage/Frequency:	
Route:	
What is the PRN specifically for?	

Contact prescribing physician if/when:

Additional comments:

Physician/NP Contact Information (*must be legible*):

Name: _____ **Phone Number:** _____

Physician/NP Signature: _____ **Date:** _____

SOAR365

Physician's Order for Medication

Medication Prescribed To: _____

Approved Over the Counter PRNs. Physician, please initial next to approved PRNs!

____ **Aches/Pain/Fever:** Tylenol (acetaminophen) 500mg, 2 tabs by mouth every 4 hours as needed.

Other: _____

____ **Seasonal Allergies/ Allergic Reaction:** Benadryl (diphenhydramine) 25mg by mouth every 4 hours as needed.

Other: _____

____ **Congestion/Cold Symptoms:** Sudafed (pseudoephedrine) 60mg by mouth every 4-6 hours as needed not to exceed 240mg in 24 hours.

Other: _____

____ **Cough:** Robitussin DM (dextromethorphan) 2 tsp every 4 hours as needed.

Other: _____

____ **Diarrhea:** Imodium (loperamide) 4mg after first loose stool, then 2 mg after more loose stool, not to exceed 8mg in 24 hours. Call doctor if no relief in 24 hours.

Other: _____

____ **Constipation/Laxative:** Milk of Magnesia (magnesium hydroxide) 30mL by mouth once daily as needed. Notify doctor's office if no BM within 3 days.

Other: _____

____ **Constipation/Stool Softener:** Colace (docusate) 100mg by mouth once daily as needed.

Other: _____

____ **Indigestion/heartburn/upset stomach:** Mylanta 30mL by mouth once daily as needed.

Other: _____

Physician/NP Signature: _____ **Date:** _____

SOAR365

Physician's Order for Medication

Medication Prescribed To: _____

____ **Nausea/Vomiting:** Emetrol 15 mL every 15 min until nausea/vomiting subsides, not to exceed 5 doses. Call doctor if no relief within a few hours.

Other: _____

____ **Sunscreen:** 30 SPF as needed for outdoor activity.

Other: _____

____ **Rashes/Itching:** Hydrocortisone cream 1%, apply to affected area 3 times daily as needed.

Other: _____

____ **Sunburn:** Aloe Gel as needed for relief.

Other: _____

____ **Minor Burns:** Cool the burn, remove clothing/items from around affected area, clean area, apply antibiotic ointment, bandage with sterile gauze loosely to protect.

Other: _____

____ **Minor Lacerations/Abrasions/Tears:** Cleanse area thoroughly, apply antibiotic ointment and cover with gauze/ dressing/bandage as appropriate.

Other: _____

____ **Insect Repellent:** As needed for outdoor activities.

Other: _____

Any Additional PRN Medications?

_____

_____

_____

Physician/NP Contact Information (*must be legible*):

Name: _____ **Phone Number:** _____

Physician/NP Signature: _____ **Date:** _____

SOAR365

Physician's Orders for Use of Devices for Medical or Protective Purposes

(Return only if applicable to your camper.)

Camper's Name:	
Date of Birth:	
Diagnoses:	**Reason(s) for Equipment:**

Therapeutic or ADL Needs	Frequency/Duration	Purpose	Special Instructions
Wheelchair with: ☐ lap belt ☐ chest harness ☐ foot straps ☐ other:			
Helmet ☐ soft ☐ hard			
AFOs: ☐ wrist/arm ☐ ankle/leg			
Gait Belt			
CPAP			
Other:			

Physicians Name Printed:	
Physicians Signature:	**Date:**
Campers Signature:	**Date:**
Guardian/Legal Authorized Representative Signature:	**Date:**

Unless otherwise revoked, this Physician's Orders for Use of Devices for Medical or Protective Purposes will **expire one (1) year from the date signed by physician**, or on the EARLIER date, event or condition described as:

SOAR365

Seizure Protocol

(Return only if applicable to your camper.)

Camper's Name: _____ **Date of Birth:** _____

In the event that an individual at SOAR365 is observed having a seizure or seizure-like symptoms and DOES NOT have an individualized Seizure Protocol on file, the following steps should be taken:

- Ease the person to the floor.
- Turn the person gently onto one side. This will help the person breathe.
- Clear the area around the person of anything hard or sharp. This can prevent injury.
- Put something soft and flat, like a folded jacket, under his or her head.
- Remove eyeglasses.
- Loosen ties or anything around the neck that may make it hard to breathe.
- Time the seizure. **Call 911 if the seizure lasts longer than 5 minutes.**

911 should be called immediately if the any of the following occur:

- The person has never had a seizure before.
- The person has difficulty breathing or waking after the seizure.
- The seizure lasts longer than 5 minutes.
- The person has another seizure soon after the first one.
- The person is hurt during the seizure.
- The seizure happens in water.
- The person has a health condition like diabetes, heart disease, or is pregnant.

Seizure reports are to be completed and submitted to the Program Supervisor the same day a seizure takes place.

Please sign and date if you would like Camp Baker to use this protocol.

Sign: _____ Date: _____

If you have another protocol you would like us to use, please provide a copy of that protocol **SIGNED BY THE PHYSICIAN/NP.**

SOAR365

Diabetes Medical Management Plan for Summer Camp

(Return only if applicable to your camper.)

Camper's Name: _____ **Date of Birth:** _____

Diabetes Type? ☐ Type 1 ☐ Type 2 ☐ Other: _____

Target Blood Glucose (BG) Range: _____

When is BG level checked? ☐ Before meals ☐ Between meals (10am/3pm) ☐ Before bed

Middle of night at: _____ ☐ Other time(s) please specify:

_____

_____

_____

Preferred site for testing BG: ☐ Fingertip ☐ Forearm ☐ Thigh ☐ Other: _____

Continuous Glucose Monitor: ☐ No ☐ Yes - If yes, what brand/model? _____

Type(s) of insulins used (please list type(s) of insulin used below, including times of day)**:** _____

_____

_____

_____

Camper's level of self-care/self-management of diabetes:

☐ Independently checks own BG/gives own insulin/counts carbs.

☐ May check BG with supervision/gives insulin with supervision/needs assistance with carbs.

☐ Requires nurse or trained diabetes personnel to check BG/administer insulin/count carbs.

Carb ratio at meal times (or if on fixed insulin therapy, skip to correction ratio below):

Breakfast: 1 unit of insulin per _____ grams of carbs.

Lunch: 1 unit of insulin per _____ grams of carbs.

Dinner: 1 U=unit of insulin per _____ grams of carbs.

Correction ratio at meal times:

BG _____ to_____ give _____ units. BG _____ to _____ give _____ units.

BG _____ to_____ give _____ units. BG _____ to _____ give _____ units.

BG_____ to_____ give _____ units. BG _____ to _____ give _____ units.

Hypoglycemia treatment:

Please note that our typical treatment plan is as follows...

1. Check BG – if less than 70, give 15g of fast carbs, recheck in 15 min.
2. If above 70, give balanced 15g carb snack.
3. If it remains below 70, repeat step 1, above.

If camper has a specific hypoglycemia protocol, please list below:

_____

_____

_____

_____

Hyperglycemia treatment, aside from mealtime insulin correction:

_____

_____

_____

_____

Any other notes to help us best care for your camper with diabetes?

_____

_____

_____

_____

_____

_____

This diabetes management plan has been approved by:

Physician/NP Name: _____ **Phone number:** _____

Physician/NP Signature: _____ **Date:** _____

SOAR365

G-Tube Medical Management Plan for Summer Camp

(Return only if applicable to your camper.)

G-tube Orders and Administration Guidelines for:

Camper's Name: _____ **Date of Birth:** _____

All feeding tube supplies, formula, and food must be provided by family/home.

Please answer the following questions for staff to care for this camper's g-tube:

- What kind of tube is it? _____
- What is the tube size or gauge? _____
- What is given through the tube? _____
- Is this camper to receive **NOTHING BY MOUTH**? _____
- Please write out feeding schedule below and amounts to be given at each feeding (including water flushes!) unless already provided. **(This can be on separate sheet as long as it is signed by the prescriber)**:

_____

_____

_____

_____

_____

_____

_____

_____

- What body position is best during feeds? _____
- How long must the camper be kept upright after feeds? _____
- How is the skin cleansed around the tube/how often? _____
- Any ointment needed for around the g-tube site **(this requires a signed PO/script)**?

_____

- Does the tube come out frequently? (pulling out, falling out, breaking, etc.) If so, please explain why and what is done in those situations. Please send extra g-tubes if this is an issue.

_____

_____

_____

Physician/ NP Name and contact information: _____

Physician/ NP Signature: _____ **Date:** _____

SOAR365

Consent to Exchange Information

I understand that different agencies provide different services and benefits, and each must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information in order to effectively provide or coordinate these services or benefits.

I _____, am giving consent for _____

_____
Individual's Address

_____ _____ _____
Date of Birth | Individual's SSN | Phone number(s) of Authorizing Person(s)

My relationship to the individual is:

☐ Self ☐ Guardian ☐ Authorized Representative ☐ Power of Attorney (medical)

Power of Attorney (other-specify): _____

The following confidential information about the individual may be exchanged (*check all that apply*):

☐ Assessment information ☐ Medical Diagnosis (*except drug or alcohol diagnosis/treatment*) ☐ Medical Records
☐ Mental Health Diagnosis ☐ Psychiatric Records ☐ Educational Records ☐ Financial Information
☐ Employment Records ☐ Criminal Records ☐ Benefit/Services (*planned/received*)
☐ Other (specify): _____

This confidential information may be exchanged between SOAR365 and the following other agencies and individuals (*check all that apply*):

☐ VA DARS regional & field offices ☐ VA DBHDS ☐ VA DDHH ☐ VA DBVI ☐ VEC ☐ VA DH ☐ SSA

☐ CSB (*agency name*): _____

Training Center (*name*): _____

DSS (*locality*): _____

School System (*name*): _____

☐ Physicians ☐ Hospital ☐ Nursing Facility ☐ ICF ☐ Hospice ☐ Group Home

☐ Family Member(s) (*print names*): _____

☐ Other (*specify*): _____

I want this information to be exchanged only for the following purpose(s):

☐ Eligibility Determination ☐ Service Coordination & Planning ☐ Other (*specify*): Urgent health situations

I want information to be shared by the following means (*check all that apply*):

☐ In writing ☐ In meetings ☐ Phone ☐ Fax ☐ Computerized Data

This consent is good until: ☐ My service case is closed ☐ Until (*date*): the end of summer camp 2026

I can withdraw this consent at any time by telling SOAR365 and the listed agencies to stop sharing information. If I ask, each agency will show me what information has been shared, and tell me why, when, and with whom it was shared. I want all the agencies checked to accept a signed copy of this form as a valid consent to share information. ***If I do not sign****, I will have to contact each agency individually to give it the information about me that it needs.*

Signature(s): _____ Date: _____
(Consenting Person or Persons)

Signature: _____ Date: _____
(SOAR365 Staff Explaining Form)

Adapted from the Commonwealth of Virginia Uniform Authorization to Exchange & Use Information Approved by the Attorney General's Office 3/10/08
SOAR365 rev 10/04; rev/rev 9/09; rev/rev 9/10; rev/rev 5/13

3600 Saunders Ave, Richmond, VA 23227 | Tel (804) 358-1874 | Fax (804) 353-0163 ● 1901 Westwood Ave, Richmond, VA 23227 | Tel (804) 358-1874 | Fax (804) 358-7595
7600 Beach Road, Chesterfield, VA 23838 | Tel (804) 748-4789 | Fax (804) 956-3571 ● 8030 Staples Mill Road, Richmond VA 23228 | Tel (804) 665-1266 | Fax (804) 262-5104