

# Camp Manatawny

## Health Care Policies and Procedures



*Transforming Lives  
for Christ for a  
Lifetime*

**JILL BARTON**  
Executive Director

jill.barton@manatawny.org  
610-707-3822

Camp Manatawny  
33 Camp Road  
Douglassville, PA 19518  
www.manatawny.org

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## Welcome!

Thank you for your help this week! In order to promote the health and well-being of our campers and staff, the camp administration has adopted the policies and procedures in this handbook. These will be reviewed annually and updated as indicated.

1. Please make sure there is a copy of your license and malpractice insurance verification on file in Ultracamp with your staff application.
2. You will receive keys to the Nurses Cabin from the camp office at the beginning of the session. Please return them to the camp office at the conclusion of the week.
3. Review the Health History information for all campers in Ultra camp to identify any campers with special needs (medications to be given, dietary needs, allergies, etc.). The camp office will inform the head cook of any food allergies one week before each summer session. The nurse should communicate to the head cook any new food allergy information that is received during registration. Please make the counselors, life guards and kitchen staff aware of any special situations. The Canteen workers should also receive a list of food allergies from the camp office.
4. All encounters must be documented in Ultracamp (including administration of first aid, medication, etc.). Information to be noted should include (but is not limited to): date and time of incident, nature of incident, treatment rendered, and outcome. If an accident happens on camp property that might involve submission to camp insurance, a paper form is available that should be completed and given to the summer camp office.
5. Any medication brought to camp (prescription and non-prescription) must be collected by the nurse and kept in the nurse's station in a locked area accessible only to the health personnel. The health personnel are responsible for administration of all medications. Each dose must be documented including name of medication, amount given, time and date (and reason if prn med) in Ultracamp. Accurate records protect the Camp and you from liability.
6. There are others on staff that are trained in first aid and CPR (such as the lifeguards). You should familiarize yourself with them in case their expertise is needed.
7. Per OSHA guidelines, universal precautions should be followed at all times.
  - a. Gloves should be worn when administering first aid. Please be aware of those who may have a latex allergy and use non-latex gloves.
  - b. Hand washing after every patient contact is essential.
  - c. All surfaces involved in patient care should be cleaned with a solution of 1 part chlorine bleach and 10 parts water.
  - d. Any reusable equipment must be properly cleaned and disinfected with
  - e. Any materials used in patient care, which becomes saturated with blood, or other body fluids should be disposed of properly using Hazardous Waste (red) bags. Please contact the director for instruction in proper dispensation of this waste.
  - f. Any patient requiring injectable medications must provide an appropriate sharps disposal unit (such container must meet OSHA guidelines, items such as jars and empty bottles are not appropriate). These should be taken home with the patient for proper disposal.

- g. Please report any accidental needle sticks to the session director for further instructions regarding needle stick protocol.
- 8. The following guidelines are provided to lend guidance in treatment of illness and injury, which may arise at a camp session. The protocols were written and reviewed by a licensed physician and may be interpreted as standing orders. Deviation from these protocols is considered as unauthorized treatment. The camp or its medical advisor will assume no responsibility for unauthorized treatment.

## Local Emergency Contact Information

Emergency Medical System (EMS/ambulance): 911 In situations where a phone call cannot be made, 911 can be texted also

Poison Control Center: 800-222-1222 <http://poisonhelp.org>

Child Abuse Reporting, State of Pennsylvania- <https://www.dhs.pa.gov/KeepKidsSafe/Pages/Report-Abuse.aspx>

Medical Advisor: Beverly J. Niehls, MD Cell: 484-769-2129 Office: 610-779-1330 (If you must call the office during the physician's hours, please be aware that you may need to leave a message for a return call, the physician may not be immediately available to speak to.)

### Local Hospitals

Tower Health Pottstown Hospital, <https://towerhealth.org/locations/pottstown-hospital> : Main Switchboard: 610-327-7000 Emergency Room: 610-327-7744 (Distance 13 miles, small community hospital)

Saint Joseph Medical Center, <https://www.pennstatehealth.org/locations/st-joseph> : Main Switchboard: 610-378-2000 Emergency Room: 610-378-2330 (Distance 19 miles-large medical center)

Tower Health Reading Hospital, <https://towerhealth.org/locations/reading-hospital> Main Number: (484)628-8000 (Distance 15 miles-714 bed Magnet recognized hospital)

Lehigh Valley Hospital-Gilbertsville <https://www.lvhn.org/locations/lehigh-valley-hospital-gilbertsville>

1109 Grosser Road, Gilbertsville, PA 19525, 888-402-LVHN (5846) (Distance 7.5 miles-neighborhood hospital with 24/7 ER and 10 bed medical unit)

### Urgent Care

Tower Health Urgent Care-Douglasville, PA (Rte 422) 1139 Benjamin Franklin Highway, Suite 114 Douglassville, PA (610)385-4444 Fax (610)385-1002 <https://towerhealth.org/locations/tower-health-urgent-care-douglassville> (Open 9am to 9 pm, 7 days a week)

### Pharmacies:

CVS 1149 Ben Franklin Hwy, Douglassville 610-385-4300

Walmart Supercenter 5900 Perkiomen Ave, Reading, PA +1610-582-0505

## Guidelines for Campers/Staff Needing Further Medical Attention

1. If not an emergency, always notify the parent/guardian prior to taking a camper for further medical attention. Families who live locally may want to pick up the child and take them to their regular physician if possible, or may have a preference of hospital if necessary. In an emergency, the parent/guardian should be contacted as soon as possible. This task could be delegated to the director or other camp representative.
2. If a camper can be transported for care safely by automobile this is preferable to calling an ambulance as these transports are often not covered by insurance and can be quite costly. A responsible adult, not the nurse who should not leave the other campers unattended, must accompany campers who leave the camp (if parents do not come to transport the camper).
3. From Ultracamp print and send "Summer Camp and Retreat Health Information [2.0]". This document includes
  - a. A copy of their Health History information
  - b. Insurance information. The camp's insurance covers accidents only, not illness or preexisting conditions. It is a secondary insurance and the parent's insurance is considered primary.
  - c. Parental/ guardian consent for treatment
4. Communicate with the director as soon as possible when a camper is being transported for further attention. The director will then communicate with the camper's counselor and anyone that would need to be aware that the camper is leaving camp. However, discussion of a camper's health with others is considered a HIPPA violation.
5. When a camper is sent off site for treatment note the location of treatment and outcome in Ultracamp. If EMS is called, please note the ambulance company and destination.
6. In the event you call an ambulance for a child, once the child is in the hands of Emergency Personnel, have someone accompany the child with whom the child is comfortable.

## Guidelines for Campers/Staff Testing of Communicable Diseases

There is no testing for any potentially communicable disease by the health care providers at camp. Any camper or staff member that has symptoms of a possible communicable disease will be required to be seen by their primary care provider or a local urgent care center. If they test positive for a communicable disease (for example, strep, COVID, flu, RSV, etc.) the current CDC guidelines for returning to camp and notifying others that may have been exposed will be followed.

## Administration of Over-the-Counter Medications

The Nurses Cabin will be stocked with commonly used over the counter medications. These are for use at the discretion of the health care staff and according to the protocols set forth in the following pages. No other over-the-counter medication should be purchased or administered to campers, unless the camper brings them and they are listed by the parent/guardian in the health information in Ultracamp.

Below are dosing instructions for some common products according to age group, in some cases the children's doses are based on weight. To convert a weight from pounds to kilograms (kg), take the weight in pounds and divide by 2.2.

### Acetaminophen (Tylenol):

| Weight (lbs)             | 6-11 | 12-17 | 18-23 | 24-35 | 36-47 | 48-59 | 60-71 | 72-95 |
|--------------------------|------|-------|-------|-------|-------|-------|-------|-------|
| Dose in mg               | 40   | 80    | 120   | 160   | 240   | 320   | 400   | 480   |
| Liquid (160mg/5mL) in mL | 1.25 | 2.5   | 3.75  | 5     | 7.5   | 10    | 12.5  | 15    |
| Chewable 160mg tablet    |      |       |       | 1     | 1.5   | 2     | 2.5   | 3     |

Use label directions or above chart as a dosage guide. <https://pandsclinic.com/infant-tylenol-dosage-childrens-tylenol-dosage-chart/>

- 6–12-year-olds: 10-15 mg/kg every 4-6 hours
- 12–18-year-olds: 325-650 mg every 4-6 hours, Maximum: 1 gm/4 hours and 4g/24 hours
- Adults: 325-1000 mg every 4-6 hours. Maximum: 1 gm/4 hours and 4g/24 hours

### Diphenhydramine (Benadryl)

- Age 6-12 12.5-25 mg every 4-6 hours
- Age over 12 25mg every 4-6 hours
- Adults 25-50mg every 4-6 hours

### Ibuprofen:

| Weight (lbs)                                | 12-17 | 18-23 | 24-35 | 36-47 | 48-59 | 60-71 | 72-95 |
|---------------------------------------------|-------|-------|-------|-------|-------|-------|-------|
| Dose in mg                                  | 50    | 75    | 100   | 150   | 200   | 250   | 300   |
| Dose of children's liquid in mL (100mg/5mL) | 2.5   | 3.75  | 5     | 7.5   | 10    | 12.5  | 15    |
| Chewable tablet (100mg)                     |       |       | 1     | 1.5   | 2     | 2.5   | 3     |
| Junior Strength Tablet (100mg)              |       |       |       |       | 2     | 2     | 3     |
| Adult strength tablet (200mg)               |       |       |       |       | 1     | 1     | 1     |

Use package directions and above chart as a guide. <https://pandsclinic.com/childrens-ibuprofen-dosage-infant-motrin-dosage/>

- a. Children: 4-10 mg/kg every 6-8 hours
- b. Adolescents: 200-400 mg every 6-8 hours
- c. Adults: 400 mg every 6-8 hours

### Imodium

|                                          |                                                                                                                |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| adults and children<br>12 years and over | 30 mL after the first loose stool; 15 mL after each subsequent loose stool; but no more than 60 mL in 24 hours |
| children 9-11 years<br>(60-95 lbs)       | 15 mL after first loose stool; 7.5 mL after each subsequent loose stool; but no more than 45 mL in 24 hours    |
| children 6-8 years (48-59 lbs)           | 15 mL after first loose stool; 7.5 mL after each subsequent loose stool; but no more than 30 mL in 24 hours    |

Use package directions and above as guidelines. <https://www.imodium.com>

- a. Children age 6-8 (20-30 kg): start with 2mg dose and repeat dose at 1mg after loose stools, no more than 4mg per day
- b. Children age 8-11 (30-40 kg): start 2mg dose and repeat dose at 1mg per dose up to 6mg per day.
- c. Children 12 and older: start with 4mg initial dose, repeat doses at 2mg up to 8mg per day
- d. Adults: start with 4 mg initial dose, repeat doses at 2mg up to 16 mg per day

### Naprosyn Sodium (Aleve)

- a. Children >12 yrs: 220mg tablets - one every 8-12 hrs
- b. Adults: 220mg tablets – two every 8-12 hrs

### Topical Medications

There are several topical medications stocked in the nurse's cabin as well. These include:

- Antibiotic cream or ointment (Neosporin, Bacitracin, etc.)
- Calamine lotion (for rashes such as poison ivy)
- Hydrocortisone Cream for itchy rashes and bites

### Camper Owned OTC medications

Campers may bring other over the counter medications with them to Camp. They should be handled the same as prescription medications brought from home. They will be collected at registration, and will need written instructions from a physician/parent/guardian for their use. Over the counter medications other than the ones listed cannot be given to campers without parental permission.

### Staff Medications

Staff that are sleeping in cabins with campers must bring all medications to the nurses' cabin. The nurse will give them access to their meds, but is not responsible for dispensing them to staff.

## Urgent Care versus Emergent Care

For the following items these definitions of urgent care and emergent care should be applied.

**Urgent care**-treatment of a non-life-threatening injury or illness. Transportation to a local urgent care center or to the staff/camper's primary care provider is needed. The decision of whether to go to urgent care or be taken to the camper's primary care provider should be made in consultation with the camper's parent/guardian.

**Emergent Care**-treatment for a life or limb threatening condition requiring immediate treatment. Transportation should be by ambulance, so calling 911 immediately upon identifying this level of care is needed is essential. For campers, 911 should be called and the camp nurse should remain with the camper until care is transferred to EMS. Notification of the parent should be the responsibility of the director or someone not directly responsible for monitoring the camper.

## Abdominal Pain

Abdominal Pain may represent something as simple as homesickness or something more serious as appendicitis. Deciding who simply needs TLC and who needs urgent hospital evaluation is a challenge. Usually a child who "looks well" is well, and a child who "looks sick" is. Most of the time a child who comes to you with a "belly ache" will have a bit of upset from the food, the heat, or too much "canteen". Viral gastroenteritis is known to go around in the summer though and may cause a mini-camp epidemic. Pre-adolescent and adolescent girls may have menstrual cramps (or something more serious such as a ruptured ovarian cyst or pregnancy). For the adults, don't forget things like gall bladder attacks and kidney stones as possibilities.

**Initial treatment:** For abdominal pain in an individual who does not look acutely ill: rest, clear liquids and Tylenol (in age-appropriate doses). For those with menstrual cramps, Aleve or Advil should be given. If symptoms persist, considering calling the parent to have the child seen by a physician.

**Urgent Care:** Pain accompanied by fever, severe vomiting, or urinary complaints. Pain that doesn't improve or worsens with above treatment Pain localized to the right lower quadrant of the abdomen. Pain with a known or possible pregnancy Pain with persistent vomiting and/or diarrhea with signs of dehydration, Colicky pain with history of kidney stones Pain accompanied by blood in vomitus or bloody diarrhea.

**Emergent Care:** Person who appears acutely ill with sweating, low blood pressure, tachycardia, high fever, dehydration, lethargy.

## Animal Bites

All animal bites penetrating the skin need to be evaluated by a physician. Treatment will include wound care, antibiotics, tetanus prophylaxis if needed, and possibly rabies prophylaxis. If the bite is from a domestic animal, the animal's shot records should accompany the patient for evaluation. If the bite is from a wild animal, capturing the animal is advised (if it can be done without risk to other individuals, killing the animal for capture is acceptable).

**Initial Treatment:** Cleanse the area with soap and water, or wound cleanser if available. Apply pressure to control bleeding. Apply a sterile dressing. Tourniquets are not advised for the treatment of animal bites, including snakebites.

**Urgent Care:** All animal bites should be evaluated

**Emergent Care:**

Uncontrollable bleeding, Disfiguring wounds, and potentially venomous snakebite

## Asthma

Asthma is the most common chronic disease of childhood. You will have campers on asthma meds. It is imperative for these children to have their medication regularly. Children with asthma should be able to participate in all camp activities if their asthma is well controlled. Asthma is also a potentially life-threatening disease and should be given due diligence in treatment. Asthma medications fall into two categories: Maintenance Steroid inhalers or nebulized steroids (fluticasone, betamethasone, etc.) Long-acting beta-agonists (serevent, foridil) Theophylline (this is rarely used in children) Multidose inhalers (albuterol, maxair, etc.) Nebulized medications (albuterol, xopenex) A camper may arrive on oral steroids; these are generally used to treat an acute, severe asthma attack. If a parent brings a child to camp on oral steroids, be especially watchful of that child, they may be at increased risk for a flare up. Maintenance medications should be given according to the prescribing physician's directions. Rescue medications should also be given according to the prescribing physician's directions. If a camper is involved in an activity, which takes them away from the camp central location, it may be advisable to send the rescue inhaler along either with the camper if he or she is old enough, or with the counselor. The following are general guidelines and do not override the prescribing physician's directions.

**Initial treatment of an acute asthma exacerbation:** Move the child to an air-conditioned environment. Administer the rescue medication according to the prescription.

**Urgent Care:** If no improvement after 20 minutes, the rescue medication may be repeated. If the child remains short of breath, urgent care evaluation is advised.

**Emergent Care:** If there is evidence of severe respiratory distress, such as inability to converse, posturing with the torso leaning forward, retractions of the abdominal or supraclavicular areas with inhalation, rescue medication should be given and EMS called.

## Back Pain

Complaints of back pain are more likely to come from the staff, from acting like kids. Common strains and sprains are usually minor and occur from overuse or incorrect lifting technique. Other causes of back pain include renal stones, kidney infection, herniated discs, sciatica, etc.

**Initial treatment:** Ice to area 20 minutes at a time every 2-3 hours Ibuprofen, Naprosyn or Tylenol in age-appropriate doses Restrict lifting to 10 –15 pounds until pain subsides.

**Urgent Care:** Back pain with weakness or numbness in a lower extremity. Back pain accompanied by fever. Back pain, which worsens or does not improve with conservative measures.

## Burns

The type of burn will direct management. First-degree burns are superficial. They cause the area to become reddened and painful. They will heal without a scar. Second-degree burns are a bit deeper into the epidermis and will cause blistering. They are painful and are at risk of developing secondary infection. Third degree burns are through the epidermis into the dermis. They cause the skin to slough and cause extensive scarring. Risk of infection is high. The area involved is also important to management. Burns tend to cause the body to lose fluids, the greater the area of involvement, and the higher the risk of dehydration.

**Initial treatment:** Cool the area with cool, moist compresses. NOT ICE, ice can cause greater tissue damage. Apply non-stick dressing (telfa). If there is a blister, leave the blister intact. If there is an area of denuded skin, antibiotic cream and a non-stick dressing should be applied. Change the dressing twice a day, cleansing the area gently and reapplying antibiotic if indicated. Age-appropriate doses of Tylenol or Ibuprofen can be given. If there is evidence of infection developing seek physician consultation.

**Emergent Care:** if any of the following situations exist: Second degree burns covering more than 5% body surface (1% is about the size of the victim's palm), or involve the face or perineum. Any second degree burn which extends circumferentially around a digit or Chest Pain

## Chest Pain, Traumatic:

When someone comes to you with chest pain associated with a trauma, like getting kicked in the pool, etc., the concern is whether there may be rib fractures or organ damage.

**Initial treatment:** Apply cool compresses to the area 20 minutes every 2-3 hours. Age-appropriate doses of Tylenol, ibuprofen, or Naprosyn.

### Emergent Care:

Anyone with a traumatic injury to the chest complaining of worsening chest pain, shortness of breath, hemoptysis, or a visible deformity to the chest

## Chest Pain, Non-traumatic:

When someone presents with chest pain not associated with a trauma, the risk for heart attack must be assessed. In a child or adolescent this is not likely, not impossible but not likely. In adults the complaint of chest pain must be taken seriously and dealt with as a life-threatening situation. Such things as reflux, indigestion, gall bladder disease, and muscle strain may cause chest pain but that determination should not be made at camp.

**Urgent Care:** All adults with chest pain should be sent for physician evaluation.

**Emergent Care:** Call an ambulance if the chest pain is accompanied by: Fainting, history of high blood pressure, angina, or previous heart attack.

## Diabetes

There may be campers as well as staff members who are diabetic. Diabetes is becoming more common among children and adolescents as our population becomes heavier. There is a direct correlation

between weight and the onset of non-insulin requiring diabetes. Individuals with diabetes should bring to camp, their medicines, their glucose monitor, any protocols for dealing with high and low blood sugars, and glucagon injection or glucose tablets if they have them. The change in diet and activity levels may cause fluctuations in blood sugars.

Children with diabetes requiring insulin should come to the nurse cabin for their blood sugar checks/finger-sticks and insulin injections, even if they take care of it on their own at home. This will give you an opportunity to check on them periodically. Campers/Staff may present with a CGM (continuous glucose monitor) and/or insulin pump. Make yourself familiar with their prescribed protocol and check in on them though out the week.

### Hypoglycemia:

Early signs of hypoglycemia (low blood sugars) may include confusion, disorientation, sleepiness, sweating, and tremors. Symptoms may start to occur at 70mg/dl or higher. Checking a blood sugar may be helpful but do not delay intervening in the situation. If glucose tablets are available, 4 tablets should be given and the blood sugar checked in 5-10 minutes. If glucagon injection is available (must be provided by camper/staff), it should be given. If neither of these are readily available sugar or a sugary substance should be used. Orange juice is naturally high in sugar so additional sugar need not be added. Soft drinks are appropriate if the only thing available. Crackers or bread are high in carbohydrate and can be given, keep in mind that some diabetes medications block or delay the breakdown and absorption of carbohydrates (Alpha-Glucosidase Inhibitors-acarbose (Precose), miglitol (Glyset)) so administration of carbohydrates may not raise blood sugar immediately if they are on this medication.

**Emergent Care:** If you have trouble bringing the sugar up or the person becomes unconscious.

### Hyperglycemia:

High blood sugars may not result in symptoms at first. Blood sugars that are persistently high may put someone at risk for diabetic coma or ketoacidosis. If a camper's blood sugars start to show a trend upwards and they have not brought a protocol with them, you may want to call the parents and see if they have instructions from their physician.

**Emergent Care:** Abdominal pain, vomiting, lethargy, and a fruity odor on the breath may herald onset of ketoacidosis. Call 911 if a diabetic develops any of these signs.

## Diarrhea

There are many causes of diarrhea, change in diet, anxiety, viruses, food poisoning, etc.

### Initial management:

Fluid replacement with clear liquids, avoid dairy products, citrus juices and heavy foods. Adhere to a bland diet (BRAT diet – bananas, rice, applesauce, and toast). You may use Imodium if desired.

### Emergent Care:

- Diarrhea accompanied by:
  - Vomiting which persists beyond 24 hours.
  - Severe abdominal pain
  - High fever
  - Signs of dehydration (dry mucous membranes, decreased tears, decreased
  - Bloody diarrhea
  - Diarrhea persisting more than 3-5 days

## Earache

Earache can be caused by an infection or inflammation of the external ear canal (swimmer's ear) or by pressure or infection of the middle ear (otitis media). Check the camper's health history to ascertain if the camper has tubes in their ears. If so, parental consultation should be made prior to drops being put in the ear.

### Initial treatment:

Age-appropriate doses of Tylenol or Motrin can be given.

Several drops of Swimmer's Ear drops may be placed in the ear and a warm compress applied.

### Urgent Care:

Significant earache accompanied by fever, sore throat, etc. Pain that lasts more than 24 hours

## Fever

Children get fevers often, usually they are a sign of minor illness such as viruses. Low-grade fever can occur from environmental heat exposure as well.

### Initial treatment:

Rest in an air-conditioned environment and age-appropriate doses of Tylenol or Advil should be given.

Fever and a hot environment create a situation where dehydration can easily occur so be careful to make sure these children are adequately hydrated.

**Urgent Care:** Fever that persists beyond 48 hrs. with conservative intervention. Fever accompanied by signs or symptoms of localized infection such as, sore throat, earache, abdominal pain, vomiting or diarrhea, pain on urination or signs of dehydration develop.

## Head Injury

Head injury may be a fairly common occurrence and most often is minor. Be careful not to dismiss a head injury too lightly as complications can be sudden and potentially serious.

### Initial treatment:

If the camper or staff member sustains a head injury with NO loss of consciousness, check the orientation, vital signs, pupillary response, strength and coordination. For all head injuries contact parent/guardian to notify of head injury.

If there are no alarm signs, ice to the area, Tylenol or Motrin for pain if needed and observation are recommended. Recheck the camper/staff member every 2-4 hours for the first 12-24 hours.

**Urgent or emergent care:** If there are any concerning findings or loss of consciousness, evaluation by urgent care center or emergency room is necessary! Give nothing to eat or drink until the person is seen. If the person has a seizure clear the area around the person to prevent injury, do not attempt to restrain them, do not place anything in the mouth, and call 911. When the seizure stops, secure the airway and protect the victim from further injury. Monitor the victim until EMS arrives.

If there is a head laceration with no other concerning symptoms, see the laceration protocol.

## Head Lice

Head lice are common among children and there may be an occasion when a camper is found to have lice. Head lice can be detected by the presence of nits on the hair shaft. They resemble dandruff but

when an attempt to remove them is made they adhere to the hair shaft. Head lice are associated with intense itching so the nape of the neck may show signs of excoriation. Head lice are quite contagious.

**Treatment of Head Lice:** If you discover a camper with head lice, the parents should be notified. Once consent is obtained from the parents, shampoo the camper with an over-the-counter shampoo such as RID or NIX and comb the nits from the hair shaft. Wash the bed linens in hot water and the comb and/or brush in hot water or alcohol. Check the other campers in his/her cabin for signs of infestation. Parents of the cabin mates should be notified so they can monitor their children for signs of infestation.

Clothing, linens and hats should be laundered in hot water. Stuffed animals and pillows should be placed in a plastic trash bag for 3 weeks before used again.

## Headache

Headache may occur because of sun exposure, fatigue, homesickness, viruses, bacterial infections, hypertension, tension, or migraines to name a few. Evaluation must take into consideration the diversity of conditions that may result in this symptom.

### Initial treatment:

Check vital signs. This may direct you to the cause of the headache. Fever would suggest the presence of an infection and should be dealt with accordingly. Elevation in blood pressure should prompt a call to the parent or the staff member's physician. Low blood pressure might suggest dehydration, which also should be dealt with accordingly. Age-appropriate doses of Tylenol or Motrin should be given. Reevaluate in a few hours to see if things have improved, if not recommend a physician evaluation.

**Emergent Care:** Headache accompanied by fever, stiff neck, lethargy or confusion, headache accompanied by the sudden onset of inability to speak or loss of function.

## Heat Stroke/Sun Stroke

Overexposure to heat and sun can lead to what is commonly referred to as sun poisoning, heat stroke, or sunstroke. Generally, this is secondary to dehydration and an elevation in core body temperature because the body's natural cooling mechanisms are compromised. Early symptoms are fatigue, headache, abdominal pain, and muscle cramps. Treatment consists of removing the victim to a cool environment and rehydration with oral electrolyte solution such as Pedialyte or Gatorade (in older children and adults).

**Emergent Care:** Symptoms are as above accompanied by vomiting, confusion, disorientation, and lethargy.

## Homesickness

Homesickness is included here to remind everyone to be sensitive to the young child who needs some "mothering". Some children will come in with physical symptoms and others will be very up front about being home sick. Gentle comfort and encouragement will heal a lot of ills. Just a word of caution though, a homesick child will try to make a case to allow a phone call home. This generally backfires and once they have heard Mom or Dad's voice on the phone the desire to leave becomes worse. Also, once having comforted the child and they have returned to their counselor and regular activities, you should keep an eye on them to make sure they are not harboring an illness.

## Insect Bites

Over the years, the camp has played host of a variety of biting insects and arachnids, bees, wasps, mosquitoes, spiders, and ticks have plagued campers and counselors alike.

### Local reaction:

Most often a local reaction is all that results from any of these bites. Redness, swelling, itching, and burning are common. Wasp stings can result in significant swelling, occasionally involving an entire extremity.

### Initial treatment:

Cold compresses to control swelling 20 minutes every 2-3 hours

Hydrocortisone (1/2 %) 2-3 times a day

Benadryl in age-appropriate doses for the itching

### Emergent Care: Generalized allergic reaction:

Observe anyone who is bitten or stung for an hour or so for signs of allergic reaction such as hives, facial swelling, shortness of breath or tightness of the throat. If there is a history of allergic reaction, the victim may have brought an EpiPen kit and physician instructions. If so, administer the EpiPen injection and give the appropriate dose of diphenhydramine. Most often the patient is instructed to proceed to the emergency room if the kit is administered. If this is the case, follow through with that protocol.

Occasionally, there is a protocol that calls for observation for several hours and 1-2 days of regular diphenhydramine doses. Again, if this is the physician protocol, follow it. When in doubt, send them out. If there is any sign of respiratory compromise, call 911.

## Lacerations

Lacerations are an area where you will have to rely on your own judgment. A small or superficial laceration can be managed appropriately at camp.

### Initial treatment:

Wash the area with mild soap and water. If minor, the wound may be steri-stripped or closed with derma bond (glue). Apply antibiotic ointment and a dressing. Check the wound once a day for signs of infection (redness, swelling, drainage, etc.). Check the patient's tetanus status, all campers should have a record of the last tetanus shot. If it has been more than 10 years since the last tetanus shot, physician consultation is recommended. The tetanus shot can be given up to 48 hours after the laceration if needed.

**Urgent Care:** If you believe sutures are necessary for adequate wound closure or after initial care the wound appears infected, urgent care should be consulted.

**Emergent Care:** In the event a laceration is severe and is life or limb threatening, call 911. Apply direct pressure to control bleeding; under no circumstances should you apply a tourniquet.

## Menstruation/Menstrual Cramps

Girls will get their periods at camp from time to time; occasionally it will be a first period that will catch them unaware and unprepared. There is usually a stock of pads and tampons in the nurse's cabin for just such an occasion (some parents may not want their daughter to use a tampon so a quick phone call

to Mom or Dad may be in order). If a young lady gets her period and has not been prepared by her parent or teacher you may need to brush up on your “birds and bees” talk.

Symptoms occurring with menses differ from person to person but may include cramps, aching in the legs and pelvis, and nausea.

#### Initial treatment:

Warm compresses can be soothing and age-appropriate doses of Ibuprofen or Aleve can be helpful. Tylenol can be used in women allergic to NSAIDs, but is less efficacious.

**Urgent Care:** If there is severe bleeding or if there is a chance that the bleeding may represent a miscarriage

## Nose Bleed

Nosebleeds generally occur because of trauma to the nose, either internal (i.e. picking) or external, as well as forced blowing and occasionally spontaneously.

#### Initial management:

Tip the head slightly forward, and pinch the nose just below the bony ridge. Apply constant pressure for 5 minutes without releasing. Ice can be applied to the back of neck or side of nose while holding pressure. Encourage the patient to breathe through the mouth and cough out blood. They should not swallow it. Blood in the stomach causes nausea and vomiting which can restart the bleeding. After 5 minutes gently release the pressure. If the bleeding resumes, repeat pressure for 5 minutes and check again. If after 3 tries, the bleeding persists, take the patient to the emergency room or urgent care center.

#### Emergent Care:

The patient complains of dizziness or passes out. If there is an elevation of blood pressure greater than 160/90 in someone who has no history of hypertension or greater than 180/100 in someone with a known history of hypertension (I have never seen a patient with a nose bleed who did not have some elevation in blood pressure.)

After the bleeding is controlled encourage the patient to take it easy for the rest of the day, no strenuous exercise, no heavy lifting. Encourage them to NOT manipulate or blow their nose for the next 12 hours. Wipe below the nostrils, not across them.

**Urgent Care:** If someone has 3 nosebleeds in one day, physician consultation is advised.

## Pink Eye

Pinkeye (conjunctivitis) is a superficial inflammation of the conjunctiva, the membrane covering the eye. Allergies, viruses, irritants, and bacteria all can cause conjunctivitis. Prescription antibiotic drops are only needed for bacterial conjunctivitis. Allergic, irritant, and viral conjunctivitis can be managed with symptomatic treatment.

#### Initial management:

Cool compresses can be very soothing. A moist washcloth is appropriate, make sure it is not shared and is laundered in hot water after use. Irrigation with saline can be helpful in the event of irritant conjunctivitis.

Anti-histamine drops (available over the counter) can be helpful with itching and burning.

\*Anyone who develops conjunctivitis and is a contact lens wearer MUST remove his or her lenses. Wearing contact lenses with conjunctivitis may cause permanent damage to the conjunctiva. Lenses must be properly disinfected or discarded.

**Urgent Care:** If there is purulent drainage (yellow or green discharge). Consider isolating a child with bacterial conjunctivitis until treated for at least 24 hours.

## Pregnancy

A pregnant camper or staff member may be treated as any other camper or staff member with a few exceptions.

1. Do not give any other medications except for Tylenol unless instructed by the camper parent/staff member
2. Encourage hydration and decreased activity in very hot weather.
3. If the patient is experiencing morning sickness, the best approach is usually keeping something in the stomach at all times. (Nibbling on crackers, pretzels, and dry cereal can be helpful.)
4. A pregnant woman with any complaints of pelvic pain or vaginal bleeding (including spotting) needs to be evaluated by her obstetrician or in the emergency room.

## Rashes

Common rashes you may see at camp include:

**Contact dermatitis** (including poison ivy and poison oak): presents with small red papules (bumps) and vesicles (blister like lesions). These are itchy and spread in the exposed area.

**Heat rash:** areas of tiny red bumps, rarely itch, often in skin folds These can all be safely treated conservatively with cool compresses, hydrocortisone cream twice daily, and benadryl for itching.

**Hives:** (Diffuse itchy red blotches) Hives usually indicate an allergic reaction and

**Urgent Care, Hives:** Unless associated respiratory difficulty, throat itching or swelling, dizziness, or passing out, or if there is exposure to a known allergen then it is an **Emergent Care** situation. If an EpiPen is available administer per instructions.

**Chicken Pox:** Most children will have had a Chickenpox vaccine so this is becoming uncommon. If a child develops a rash, which looks like small blisters on a red base, isolate the child and have the parents come and take the child for evaluation.

**Scabies:** a mite that burrows under the skin causes Scabies. The lesions are minute red bumps that are intensely itchy and form small lines primarily in the webs of the fingers and in the area of the waistband and groin. If you suspect scabies, the child should be isolated until taken to **Urgent Care: Scabies**.

**Shingles:** Since the advent of the varicella vaccine, there has been an increase in the incidence of shingles in children. Shingles occurs as a result of the reactivation of the varicella virus. It appears very similar to chickenpox but is limited to one area of the body.

**Urgent Care, Shingles:** If you suspect shingles, a physician should see the patient ASAP, as early treatment is important to limit complications.

## Sore Throat

Sore throat occurs frequently and is most often caused by viruses (including mononucleosis). Occasionally a case of strep throat will occur at camp. Deciding who can be managed at camp and who needs physician evaluation can be difficult.

### Initial management:

Lozenges, chloroseptic and age appropriate doses of Tylenol can be helpful in treating a camper/staff member with a sore throat. Gargling with salt water can be soothing, mix ¼ tsp of salt with 4 oz of water and gargle 3-4 times a day or as desired.

**Urgent Care:** Fever over 101.5 F, worsening symptoms, lethargy, vomiting, shortness of breath, difficulty swallowing or rash.

## Seizures

Children may attend camp that have a seizure disorder and are on anticonvulsant medication. In this case, it is critical they receive their medications as prescribed. Seek the kids out if need be. If they are persistently difficult to find and resist their medications, call the parents. If the parents are unsuccessful in improving the child's compliance, send the child home. The child's safety cannot be compromised. Even children with controlled seizure disorders and who comply with treatment may have a break through seizure.

### Management of a seizure:

Clear the area to avoid injury to the child.

When the seizure subsides, roll the patient onto their side to avoid aspiration.

### Emergent Care: for all seizures

Don't panic. Don't put anything in their mouth – especially not your fingers. People don't really swallow their tongue. They may have an airway obstruction, which can be relieved by rolling the patient onto their side. When the seizure activity subsides, the patient may be very confused and disoriented. Gentle reassurance is needed until the "post ictal" period resolves. Hospital evaluation is necessary even if the patient comes out of it to check their medication levels and assure that nothing else is wrong.

## Splinters/Foreign Bodies

Splinters can be tricky, especially in small children.

Cleanse the area with soap and water, if it appears that you can easily remove the foreign body with tweezers, do so. If you choose to remove the object, wash the area again and apply antibiotic ointment and a bandage. Check on the area in 24 hours to assure no infection is present.

**Urgent Care:** If a splinter is imbedded or becomes infected or if a foreign body of the eye does not wash out with saline solution.

## Sprains/Strains/Fractures/Dislocations

Injuries will occur at camp. Injuries that present with pain with or without swelling can be treated conservatively with ice elevation and rest. You can give appropriate doses of Tylenol or Motrin for pain.

**Urgent Care:** If there is significant loss of function or if things do not start to improve with conservative management.

**Emergent Care:** If there is an open fracture or visible deformity of the limb, it is recommended that EMS be called. Transporting this patient in a private vehicle is a potential liability. Do not give the patient anything to eat or drink, not even water, while waiting for the ambulance. These injuries usually require surgery and giving the patient anything by mouth will delay the procedure.

## Submersion/Near Drowning

After a water rescue, the victim should be evaluated thoroughly. If the victim was conscious throughout the incident, and is in no distress, observation in the nurse's cabin for a couple hours is advised.

**Emergent Care:** If the victim has been unconscious for any period, however short, if CPR was started or if there is any residual respiratory distress, the victim should be sent to the emergency room for evaluation by ambulance. (It is recommended that you are aware of other staff members that are First Aid/CPR certified and can utilize their expertise in this area.)

## Sunburn

Sunburn is fairly common and relatively minor. Minor cases can usually be managed with cool compresses 20-30 minutes every 2-3 hours. Avoid ice directly on the skin as more tissue damage may result. Apply hydrocortisone 1% twice a day to the area. Age appropriate doses of Tylenol or Ibuprofen can be given for pain. If a significant area of skin is involved, there may be significant fluid loss as well. Make sure to replace fluids and encourage adequate hydration. As sunburn heals, there may be a lot of itching. Benadryl in age appropriate doses may be helpful to relieve itching.

**Urgent Care:** If there is significant blistering.

## Tick Bites

There are two species of ticks endemic to eastern PA.

The **common wood tick**, these are the kind that you pull off your dog. They are about 3-4 mm in diameter. They are dark colored with white marks near the head. The wood tick can carry Rocky Mountain Spotted Fever. The incubation period for Rocky Mountain Spotted Fever is 3-10 days and presents with fever, chills, body aches and abdominal pain. Diffuse red papules usually develop on the third day.

The **deer tick**, these are much more difficult to see. They are 1/2-1mm diameter and are dark orange brown with black markings near the head. These ticks can carry Lyme disease. The incubation period for Lyme disease is 10-14 days. Lyme disease presents with flu like symptoms. 40% of patients with Lyme disease will develop the classic "bull's eye" rash.

**Initial Treatment:** If someone comes to you with a tick on the skin, remove the tick by grasping the tick at the skin surface and pull firmly, use tweezers if they are available. It is a common misconception that the tick burrows into the skin, the pincers may become imbedded, but the tick will not burrow. If

the pincers remain after you pull the tick off, resist the temptation to dig it out; they will be expelled by the bodies' natural defense mechanism. Apply antibiotic ointment and a dressing. Keep an eye on the area for signs of secondary infection.

Both Rocky Mountain Spotted Fever and Lyme Disease are easily treated with oral antibiotics. If a child comes to you with a tick, let the parent know so they can keep an eye on them and take them to a doctor if they become ill.

\*There is now a recommendation from the CDC to give preventative antibiotics to anyone who gets bitten by a deer tick and it has been attached for more than 24 hours. You may want to discuss this with the patient or their parents and they can contact their personal physician for instructions.

## Toothache

This is more likely to be a staff complaint than a camper complaint. Toothaches usually occur because of dental caries or abscess. Age-appropriate doses of Tylenol or Motrin can be given. If pain is severe Tylenol and Motrin can be given together, but do not give more than the recommended dose. Higher than recommended doses of Tylenol have been associated with liver failure. High doses of Motrin can cause ulcers. If the pain is not controlled with over-the-counter analgesics, consult a local dentist (see the list of numbers at the beginning or check the yellow pages). The emergency room and local urgent care centers do not have dentists on duty and can provide antibiotics for infection and stronger analgesics but a dentist will still be needed for definitive treatment.

## Vomiting

Nausea and vomiting can be a symptom of viral gastroenteritis, food poisoning (pray this never happens at camp) or heat stroke. Less frequently, pregnancy or appendicitis may be responsible.

### Initial treatment:

1. Rest in air-conditioned environment.
2. When the vomiting subsides, start fluid replacement.
  - a. Wait until there has been no vomiting for 1 hour. Start small amounts of clear liquids: flat soda, sweetened tea, Jell-O, Kool-Aid, apple juice: avoid plain water, milk, and orange juice. Gradually increase the amount.
  - b. When there have been no vomiting and clear liquids are being tolerated for 4-6 hours, small amounts of bland foods like saltines, dry toast, dry cereal, plain rice or pasta, applesauce, bananas can be given. When clears and bland foods are well tolerated for 24 hours, the diet can be expanded but continue to avoid greasy, heavily spiced and dairy products for 72 hours.
  - c. Activities can start to return to normal after no vomiting for 24 hours.

### Urgent Care:

- a. The vomiting cannot be controlled after 8-12 hours in a child, or 12-24 hours in an adult
- b. Dehydration develops as evidenced by decrease in urination, dry mouth, sunken eyes, or lethargy

## Self-Injury Policy

Initial policy 2015; Reviewed June 2026

**Purpose:** In keeping with the camp's values, vision and aims, this policy aims to address the issue of self-injury:

How to deal with campers who self-injure and how to offer support in the short and long-term.

To provide support depending upon the individual needs.

How to support staff members who come into contact with people who self-injure.

How to prevent self-injury from spreading within camp.

To have clear guidelines for staff – who needs to be informed, when do parents and outside agencies need contacting?

Education about self-injury for campers and staff.

What is self-injury? Self-injury is any deliberate, non-suicidal behavior that inflicts physical harm on someone's own body and is aimed at relieving emotional distress. It can include cutting, scratching, burning, banging and bruising, overdosing (without suicidal intent) and deliberate bone-breaking/spraining.

### Risk factors associated with self-injury:

Mental health disorders including depression and eating disorders

Drug/alcohol abuse, and other risk-taking behavior

Recent trauma e.g. death of relative, parental divorce

Negative thought patterns, and low self-esteem

Bullying

Abuse – sexual, physical and emotional

Sudden changes in behavior and academic performance

### Suicide:

While self-injury and suicide are separate, those who self-injure are in emotional distress, and those who end their lives are also in emotional distress. It is vital that all emotional distress is taken seriously to minimize the chances of self-injury, and suicide. All talk of suicide and warning signs must be taken extremely seriously.

### Staff Expectations:

Listen to campers in emotional distress calmly and in a non-judgmental way.

Report any self-injury disclosed to a staff member, regardless of whether it happened at camp or previous to camp, to the nurse and director. This should happen as soon as possible and no later than 24 hours from disclosure/recognition.

Not make promises (e.g. assuring confidentiality) which can't be kept.

Reassure campers that in order to seek health and happiness people need to know about their problems so that they can help.

Promote problem-solving techniques and non-harmful ways to deal with emotional distress

Enable campers to find places for help and support

Provide accurate information about self-injury

Widen their own knowledge about self-injury and mental health disorders

**Camp Nurse Expectations:**

Keep records of self-injury incidents and concerns

Keep up-to-date with information about self-injury

Communicate concerns with director

Contact parent(s) at the appropriate time(s). Involve the camper in this process. Inform the parent(s) about appropriate help and support for their child which is available.

Know when people other than parents (e.g. social workers, educational psychologists) need to be informed

**Camper expectations:**

Not display open wounds/injuries. These must be dressed appropriately

Talk to the appropriate staff member if they are in emotional distress

Alert a staff if they suspect a fellow camper of being suicidal or at serious risk of harm to themselves, and know when confidentiality must be broken

**Parents Expectation:**

Endorse the camp's approach to self-injury education

Work in partnership with the camp

**Date for Review** - policies should be reviewed every 3 year