Camp NBB Standing Medical Orders
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Nurses must follow CNO standards for the administration of medication including knowledge of the appropriate the dosage, use, contraindications and interactions of medications while following the 5 Rights of administration. Always assess for medication allergies prior to administration.
Always utilize clinical judgement, if unsure of assessment, interventions or required skills consult team leader or MD.

Anaphylaxis: Anaphylaxis: EMS should be contacted immediately if anaphylaxis is suspected. Administer epipen OR administer 0.3mg (0.3ml) or 0.01mg/kg for children of 1:1000 epinephrine IM every 5-15 minutes if no response or an inadequate response or sooner if clinically indicated. You **may** also give 25-50mg of diphenhydramine PO or IM. Provide supportive care and protect airway. Initiate IV 0.9% NaCl/D5NS if within skill set. Salbutomol 2-4 puffs by aerochamber or 2.5mg (1ml) via saline nebulizer may be added for children with wheezing or asthma. Nebulizer not recommended due to COVID-19.
*Epi-pen JR should be used for children

Animal Bites: Administer first aid according to severity of bite, clean with soap and water and irrigate with water or saline to remove debris. Consult MD, public health department and local police as needed. assess the need for rabies prophylaxis (wild animal bites), anti-biotics therapy and date of last tetanus booster. When possible and practical, camp staff may help with public health calls as required.
*In the unlikely event of a poisonous snake bite (the Massassauga rattle snake is the only poisonous snake native to Ontario) Insure area is safe, call EMS immediately, keep victim calm and have them sit down, keep injured limb below the level of heart, remove clothing, shoes jewelry from area of bite. DO NOT: elevate limb; cut the wound; attempt to suck out venom; apply tourniquet, ice or water to site; or give the victim alcohol or caffeine

Asthma: Assess Vital signs including Oxygen saturation, along with respiratory rate, temperature, blood pressure, and heart rate. Assess air entry, wheezing, suprasternal refraction, and scalene muscle contraction (signs of work of breathing). PRAM scoring may be used to categorize as mild/moderate/severe. (see Paeditric Asthma Clinical Pathway). CONSULT MD. If O2 sat <92%, administer oxygen. Give the patient 2-4 puffs of salbutamol (but up to 8 puffs could be administered) via aero-chamber. Allow 30 seconds between puffs. If patient requires continuous oxygen then use nebulizer and administer salbutamol 2.5mg (if 10-20kg) (1ml) to 5mg (if >20kg) (2ml) with saline via nebulizer. Nebulizer not recommended due to COVID-19.

Bee/Wasp Stings: Remove embedded stinger if present by scraping with the edge of stiff card (eg. Credit card). Wash area thoroughly with soap and water and apply ice, treat pain with acetaminophen or ibuprofen as per weight. Observe patient for signs of anaphylaxis. See anaphylaxis interventions above.

Cough/Cold/URTI: Assess air entry and lung sounds, if decreased air entry or adventitious sounds auscultated consult MD. Encourage fluids, rest and hand hygiene, demonstrate sleeve cough/sneeze and offer hot water + lemon + honey. If patient insistent may receive Buckley's as

per package direction or cold & sinus tablets, but do not offer. **COVID screening pathway should be applied to these patients.**

Burns, minor: Apply **cool** or tepid water to affected area for 5-20 minutes. Assess the need for MD intervention or emergency treatment (severe 2nd and 3rd degree burns). Clean with soap and water, apply polysporin antibiotic ointment to affected area and apply gel burn dressing, or sterile gauze dressing if unavailable. Flamazine is not recommended. Protect burn from sun with use of additional clothing. Treat pain with acetaminophen/ibuprofen per package instructions and/or ice. Monitor for signs and symptoms of infection.
*For severe burns transport victim or contact EMS, provide supportive care.

Burns, sun: Assess for severity. Apply Solarcaine gel/spray and/or aloe gel (from HC fridge) to affected area. Assess access to sunscreen and educate about sun safety, for younger campers this conversation should also be had with counselors. Severe sunburns (blistering or >18% using rule of 9's) should be assessed by MD.

Blisters, intact: Assess cause of blisters. Clean area with soap and water. If blister remains intact (fluid filled) in an area where it is unlikely to rupture, do not pop it and instruct patient not to pop it. However, is it is located in an area where rupture is likely to occur through regular camp activities; clean INTACT skin with alcohol swab for 15 second and allow to dry, use sterile needle rupture blister and drain fluid. Spray with Bactine, allow to dry and cover with appropriately sized bandage – should be non-stick, ideally with polysporin. Monitor daily for infection, change bandage PRN. Encourage patient to keep feet clean and dry and to wear socks with well-fitting shoes. Parents may need to be contact for additional pairs of shoes.

Blisters, ruptured: Assess cause of blisters. Clean with soap and water and irrigate wound with sterile saline, assess for signs of infection and trapped debris. If debris is present, use hydrogen peroxide to aid removal. If skin flap still present, reposition to cover raw skin. Apply polysporin ointment and cover with appropriate-sized bandage. Monitor daily for infection and change bandage PRN.
*Hydrogen peroxide should NOT be used to clean a wound unless debris is present on wound bed as it is cytotoxic and can delay healing.

Calls home to camper parents (proactive whenever possible and prior to treatment whenever possible] There is no discretion – these calls are to be made automatically by the treating health care professional and documented on the patient chart:

- Head injury (and follow-ups daily until cleared)
- Invasive treatment – includes needles, stitches, suppositories
- Any prescription of any kind without exception
  (includes topical)
- Any dental referral
- Any referral for outside medical care

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- Any transport to clinic or hospital
- Any allergic reaction other than routine localized
- Any injury or illness that would be visible in a photograph i.e. crutches, splint, sling, bandage, black eye, etc.
- Burn requiring treatment
- Head lice
- Changes to medication
- Anything requiring isolation
- Mental health issues
- Any breathing emergencies (including asthma requiring treatment)
- Any overnight or extended stay in the health center (longer than a routine triage and short observation)
- Any unusual medical condition or symptom discovered while at camp (i.e. cyst, lump, etc.)

Chaffing: Assess cause of chaffing. If areas of tenderness are on feet and blisters have not yet formed apply mole-skin to affected area. Promote socks with shoes and keeping feet clean and dry, parents may need to be contacted for an additional pair of shoes. For chaffing in other areas (inner thighs being most common) apply ice/cold cloth to painful area, dry area and hydrocortisone or betamethasone cream to affected area twice-a-day until resolved. Encourage properly fitting clothing, antiperspirant can be applied to areas of skin-on-skin contact to decrease friction.

Conjunctivitis (pink eye): Assess for bilateral vs unilateral infection, presence and quality of discharge (watery vs purulent), symptoms of viral infections or allergies. For viral or allergic conjunctivitis administer saline eye drops for irritation TID. If bacterial conjunctivitis is suspected consult MD. Encourage frequent hand hygiene and discourage patient from touching eyes/face (wearing sunglasses may help prevent touching of eyes). **COVID screening pathway should be applied to these patients.**

Constipation: Determine date of last bowel movement, usual bowel pattern and medications that may contribute to constipation. Assess abdomen for tenderness, distension, bowel sounds and palpable stool. Administer MoM, lactulose, ducolax, Metamucil or PEG etc PO, if ineffective consider ducolax suppository or Fleet enema. Encourage fruits and vegetables, fluids and exercise. Consult MD interventions continue to be ineffective.

Concussion: see head injury

Cuts & Abrasions: Determine how injury occurred. Assess for debris in wound, if very dirty wash with soap and running water (if tolerated) and then irrigate with sterile saline. If debris remains present despite irrigation, hydrogen peroxide may be used to aid in its removal. Achieve hemostasis if wound is bleeding using direct pressure or chemical hemostatic agent. Assess the

need for approximation of edges using sutures or dermal glue (derma-bond). CONSULT MD for sutures or derma bond, and do not apply without consulting MD first. LET gel (if available) should be applied to wounds that may require closure.
Cover with appropriate sterile, dressing and secure. Determine need for tetanus booster. Patient should return to clinic to assess for infection and to change dressing if needed.
*See Hemorrhage for wounds that are bleeding profusely, or if arterial involvement is suspected
**Wounds should not be left open to air to "dry out" this increases healing time, increases chance of infection and can lead to scarring.

Dental Emergencies: Consult MD for immediate interventions. If permanent tooth is knocked out handle tooth by crown (chewing surface) NOT root, clean with sterile saline and save in sterile saline or milk, if unavailable use patients saliva, use water as a last resort. If it is known that tooth is a baby tooth it does not need to be saved/replaced. Patient should be assessed by dentist or in ED if tooth loss is traumatic, tooth is broken or adult tooth is lost. Assistant director to make arrangements for visits to dentist or orthodontist.

Dehydration: Presents with headache; nausea; glassy, sunken eyes; weakness; dry mucus membranes; tachycardia and hypotension. Patient to remain in health center taking oral fluids (Gatorade, gastro-lyte or water) until they void, colour of urine should be assessed. Allow them to rest in health center until feeling better. Be conservative with administration of analgesics for headache and anti-emetics.
*Elevated temperature, combined with dry, flushed skin and absence of sweating suggests heat stroke and is a medical emergency, EMS should be contacted immediately, and IV fluids initiated if within skill-set. Undress child and spray with tepid water.

Diarrhea: Assess frequency, physical characteristics of stool and presence of blood. Assess for signs/symptoms of dehydration and fever. Encourage fluids (Gatorade, gastrolyte or water), BRAT diet. Do not give anti-diarrheal medication unless source has been determined not to be infective. If diarrhea is related to antibiotic therapy probiotics can be offered. If febrile or accompanied by nausea and/or vomiting admit patient to health center and isolate for 24hrs post last symptom. Monitor for additional cases. If ≥4 cases present to health center, isolate those affected, begin line list, contact public health and obtain stool sample. **COVID screening pathway should be applied to these patients.**

Ear Ache: Assess for history of frequent ear infections. Using otoscope assess ear canal for presence foreign bodies, redness, discharge and wax build-up; assess health tympanic membrane. Acetaminophen or ibuprofen PO and auralgan drops as per package directions for pain. No swimming (head underwater) for 24 hrs minimum. If infection is suspected consult MD.

Eye Trauma/Foreign Body: Flush eye with saline or eye rinse using eye cups or eye-wash station (located in health center) for 15 minutes. CONSULT MD for eye exam. Have MD examine

cornea for abrasions or scratches using Fluorescein dye strips and blue light on ophthalmoscope, areas of increased dye up-take suggest damage. Protect eye with eye patch or pad as necessary. If available, tetracaine eye drop anesthetic can be applied prior to MD assessment.

Fever: Determine cause of fever. For fever due to suspected illness treat with acetaminophen/ibuprofen as per package instructions and monitor patient in health center for minimum of 4 hours. Not pharmacological interventions may include sponging with tepid water, removing additional clothing and minimal covering. Note, patient should covered lightly to prevent shivering. Do not apply ice, Do not throw patient in the lake or give cold shower, Do not administer ASA. **COVID screening pathway should be applied to these patients.**
*See dehydration for fever related to suspected heat stroke

Fainting: Assess consciousness, begin CPR if required. Assess head-to-toe for any signs of trauma paying particular attention to neurological status and attempt to determine cause of fainting. Clear C-Spine before moving patient. If C-spine clear, transport to health center, patient must be evaluated by MD. Treat according to MD recommendations. No swimming until cleared by MD.
*See dehydration for fainting suspected to be related to hypovolemia.
**See spinal injuries for c-spine interventions.
***See head injuries for concussion interventions

Fracture, obvious: Assess CSM distal to injury. Immobilize and splint arm in position most comfortable for patient, securing above and below injury and recheck CSM. For open fractures, irrigate with sterile saline to remove any large debris, cover with loose sterile dressing, immobilize and splint. Treat pain with ice, acetaminophen, ibuprofen or naproxen by weight, and opioid adjunct (Tylenol 2/3 or morphine) as directed by MD. Transport to hospital for x-ray, reduction and casting. If Do not attempt to reduce fracture.

Fracture, suspected: Assess need for imaging using Ottawa Rules (ankle, knee, wrist), if cannot be cleared consult MD for further assessment. If fracture is suspected, immobilize and splint injury, treat pain with ice, acetaminophen, ibuprofen or naproxen by weight, and opioid adjunct (Tylenol 2/3 or morphine) as directed by MD. Transport to hospital for imaging.
*See sprains and strains for injuries determined not to need imaging.

Gastrointestinal Upset, non-specific: Assess specific signs and symptoms and see appropriate topic headings for interventions. Offer pepto-bismol, or antacid as directed by package for non-specific symptoms, encourage fluids. Direct patient to return if symptoms worsen or do not resolve.

Headache: Attempt to determine cause and previous history of headaches. Acetaminophen or ibuprofen per package instructions. If cause is suspected to be due to dehydration, hold analgesics and encourage fluids and rest.

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Head Lice: Treatment and follow-up as per The Lice Squad

Head Injury/Concussion: All campers/staff who experience a head injury must be seen by health center staff. For head injuries involving loss of consciousness, a fall from a height >3ft, or high speed (eg. from tubing) victim should be assessed at the scene using spinal precautions. Determine mechanism for injury, and history of concussion. Determine the need for EMS activation. Preform neurological assessment including assessment of level of consciousness, orientation, cranial nerves, cerebellar function, and cortical function. Palpate head for swelling/tenderness/bleeding, and assess c-spine for tenderness or decreased ROM. Use Acute Concussion Evaluation (ACE) Tool to assess and document initial concussive symptoms and at re-evaluation. If patient is exhibiting ANY concussive symptoms they are to be admitted to health center for physical and mental rest in quiet room and evaluated by MD ASAP. If patient experiencing any "red flag" symptoms such as seizures, impaired memory, decreased level of consciousness, slurred speech, worsening headache or vomiting patient should be seen in the emergency department or EMS activated. Patients admitted need to be monitored frequently but they should be allowed to sleep do not wake patient for assessment unless concerned that there has been a change in neurological status. Patients should remain admitted to health center and return to activity should occur in a step-wise fashion. Any activity that causes symptoms to occur should not be engaged in. For headache patient may receive acetaminophen as per package direction. For moderate concussions, recovery at home should be considered.
*See Spinal Injuries for appropriate spinal interventions
**Persons with concussions require above all else REST and waking patients for neurological assessments provides unreliable data.
***All head injuries require a call home to parents and completion of head injury form

Hemorrhage, severe: Ensure scene is safe before attending to patient. Remove clothing to visualize injury. Determine the need for EMS. Attempt to achieve hemostasis by applying firm, direct pressure to wound at site of bleeding with absorbent dressing (large gauze, or ABD pad if available, and maintain pressure even after dressing secured. Absorbent dressing alone does not adequately replace the need for ongoing firm direct pressure. Do not remove dressing if it becomes saturation as this will dislodge any clot that has formed, apply additional dressings on-top of each other. Pressure may also be applied above wound on supplying vessel if source can be determined. If wound continues to bleed apply combat-application-tourniquet above injury, while continuing to apply direct pressure. If bleeding continues a second tourniquet may be required. Keep patient calm, alert and warm until EMS arrives. Initiate IV fluids if within skill set.
*Bleeding from large arteries such as the femoral artery require A LOT of pressure, it is not uncommon to kneel on wound to apply sufficient pressure.
**A tourniquet can be in place for up to 2hrs, longer than this and the risk of distal tissue damage resulting in amputation increases. DO NOT allow this to prevent application of tourniquet, this is a lifesaving intervention.

Impetigo: Complete thorough skin assessment including groin, as it is a very contagious infection. Apply fucidin cream three times daily and monitor closely for spread or worsening

infection. Attempt to keep affected areas covered. Consult MD for worsening/severe infection, infection covering large area of body or near eyes. Review hand hygiene, personal hygiene and stress the importance of not touching rash.

In-grown Toenail: Wash with soap and water. Assess for presence of infection requiring PO antibiotics, refer to MD as necessary. Have patient soak foot in hot water with 60ml of Epsom salt for 10 minutes, dry foot. Twist a small piece of cotton-ball with Fucidin ointment so it is 1-2mm thick. Using needle nose forceps push cotton underneath affected nail so that it exerts gental upward pressure on nail. Cover with 2 Band-Aids, one over the top of toe and the second around its circumference to keep first Band-Aid in place. This is to be done twice a day until resolved. Encourage patient to keep feet clean and dry, and to cut nails straight across. Do not force cotton under toe, do not excise nail. Severe cases should be referred to MD.

Insect Bites, clean & closed: Goal is to prevent scratching and development of open wounds, if you see a camper with a large number of bites, inform counsellor or unit/section head that camper must be seen in Health Center ASAP. Wash affected area with soap and water, apply diphenhydramine cream and polysporin cream twice a day to bites and cover with rolled-gauze. Administer non-drowsy allergy medication (Cetirizine or loratadine) as per package directions for day-time relief, administer diphenhydramine as per package directions prior to bed if bites are causing sleep disturbances. Encourage use of bug spray with high % of DEET and long, loose fitting clothing (yoga pants and other tight-fitting clothing are not effective at preventing insect bites).

Insect Bites, clean & open: Goal is to prevent development of infection and scaring. Clean affected area with soap and water. Apply diphenhydramine cream and fucidin ointment to bites three times a day and cover with rolled-gauze. Assess for signs of developing infection. Administer non-drowsy allergy medication (cetirizine or loratadine) as per package directions for day-time relief, administer diphenhydramine as per package directions prior to bed if bites are causing sleep disturbances. Encourage use of bug spray with high % of DEET and long, loose fitting clothing.

Insect Bites, infected: Wash affected area with soap and water. Consult MD for need for oral antibiotics. If oral antibiotics not required; Apply diphenhydramine cream and fucidin ointment to bites three times a day and cover with rolled-gauze. Assess frequently for worsening infection, cellulitis or systemic infection. Administer non-drowsy allergy medication (cetirizine or loratadine) as per package directions for day-time relief, administer diphenhydramine as per package directions prior to bed if bites are causing sleep disturbances.

Nasal Congestion: Determine cause of congestion. If patient has a history of environmental allergies, administer antihistamine (cetirizine or loratadine preferred over diphenhydramine) as per package directions. If cause is determined to be due to URTI encourage fluids, and administer saline nasal spray 3-4 times a day. If congestion is severe 0.9% NaCl nebulizer treatment may be helpful in thinning secretions. Encourage patient to blow nose, instead of

"sniffing" and review hand hygiene. **COVID screening pathway should be applied to these patients.**
*See cough Cough/Cold/URTI and Sore Throat for treatment of accompanying symptoms

Poisoning or Overdose: Determine substance ingested and contact poison control and follow their recommendations. If opiate overdose is suspected administer intranasal naloxone or IM naloxone if available as per BLS guidelines at 0.4mg IM or 2mg IN every 4 minutes (multiple doses may be required) and contact EMS.

Poison Ivy: Remove any clothing worn during exposure or that has been in contact with rash, have patient wash hands (including under fingernails) and effected area with warm soap and water. Apply cool compress, calamine lotion (not to face or genitals) or diphenhydramine cream, administer PO diphenhydramine. Patient should be assessed by MD for PO prednisone if large area is affected or if rash is on face or genitals. Discourage scratching and monitor for infection.

Pregnancy, suspected: Determine the date of the first day of last menstrual period, date of intercourse, if any method of birth control/contraception control is in use and why patient believes they may be pregnant. If it is determined that intercourse was unprotected and occurred within the past 72hrs, administer Plan B, provide counselling on safer-sex practices and give patient 2 condoms (confirm patient understands proper use) and recommend patient is screened for STIs. Patient should return in 7 days or if next menstrual period is >3 days late for urine pregnancy test. If pharmaceutical birth control (or IUD) is in use, provide counselling and suggest STI screening, provide 2 condoms. Have patient return to clinic 7 days after intercourse or if start of next menstrual period is >3 days late for urine pregnancy test. If pregnancy test in either test is positive, repeat test and consult MD. *Ovulation occurs ~14 days after start of LMP based on a 28 day cycle, sperm can survive for ~72hrs in the vaginal canal. Generally a strip pregnancy test will test positive ~7days after fertilization (or 5 weeks after last menstrual period)

Sore Throat: Assess for redness, white spots or streaks, enlarged tonsils, swollen lymph nodes, fever, history of recurrent strep throat or mononucleosis, symptoms of URTI. If febrile, with white spots or streaks WITHOUT URTI symptoms or if patient has a history recurrent strep throat infection, conduct rapid strep test and send throat swab to lab (if negative RST). If rapid strep test is positive, consult MD. Offer salt-water gargle TID, chlorospetic throat spray and ibuprofen PRN for pain. If mono is suspected obtain blood sample for mono-spot or send patient to lab in Haliburton for blood work. **COVID screening pathway should be applied to these patients.**
*Rapid strep tests may give false negatives, throat swab should be sent to the lab even if rapid is negative.

Splinters: Engage the help of counsellor to provide distraction to child during extraction. Clean area with soap and water and dry. Spray with Solarcaine (contains lidocaine) if camper is fearful. Ice can be applied to the affected area for 5-10 minutes prior to removal, as this is effective for anesthesia/analgesia. Clean fine point forceps by scrubbing tips with alcohol swab for 15 seconds and allowing to dry. If tip of splinter protrudes above skin, grasp with forceps

and gently pull splinter out at the same angle as entry. If tip does not protrude above skin, use tip of forceps (or if stubborn use sterile needle) to gently pick skin at site of splinter entry until tip of splinter can be grasped. Once splinter is removed spray with bactine and cover with bandage for large splinters. If splinter cannot be removed and is not causing discomfort, allow it to remain in-situ and have camper return the next day for reassessment and another attempt at removal.
*Many campers are afraid of needles, and telling them you are going to use a needle to remove a splinter can result in increased fear and anxiety.

Spinal Injuries: Assessment should be done at site of injury not at health center, assessment should be completed with MD and at least 1 RN. Emergency air way, oxygen, portable suction, cervical collar. Attempt to determine mechanism and severity of injury ASAP supplies may be necessary and EMS activated. Once on scene maintain spinal alignment in position found while protecting/maintaining airway. Support head with hands to reduce angular movement of the c-spine. Assesses neurological status, level of consciousness, and vital signs. Start clearing the spine beginning with c-spine and progressing caudally. If spine cannot be cleared, maintain spinal alignment, protect airway and monitor until EMS arrives, begin IV fluids if within skill set. If spine is clear have patient sit, assess for pain, dizziness, numbness, then have patient stand and assess for the same. If no impairment patient may return to cabin/usual activities (if consensus among team). Patient should be re-evaluated frequently by MD. If patient shows sign of concussion, they should be admitted to health center for rest and observation.
*Suspected spinal injuries should not be immobilized by boarding or strapping. A cervical collar MAY by applied by a trained professional if it is within their knowledge and skill to do so, but it is not necessary.

Sprains & Strains: Determine the possible need for imaging using Ottawa Rules, consult MD as necessary. Rest, Ice, Compression and Elevation. Elevate injury ~30 cm above heart and use cryo-cuff/boot for cryotherapy and compression for 15 min, or apply ice and compression/elastic bandage (tensor), check distal circulation 5 min after application of compression and adjust tension as necessary. For lower extremity injuries crutches may be required, adjust height so that the top is 3-4 fingers BELOW the armpit and instruct patient in their use. Administer acetaminophen, ibuprofen or naproxen for pain according to package directions.
*Elastic/Tensor bandages are not designed to provide joint support and should not be used for this purpose. If a patient requests one for support, offer appropriate brace.
**When using crutches weight should be supported with forearms NOT on armpits, this may result in long-term nerve damage.

Ticks: A tick-bite is only a tick-bite if there is a tick attached. Remove tick by grasping it as close to the skin as possible with forceps an pulling straight up or by using a “tick-key”. Ensure entirety of tick has been removed. Clean area with soap and water, entire body should be checked for additional ticks. Do not discard tick, determine if tick is Deer Tick. If so, place in medication or specimen container labelled with date and location found and send to local

public health for testing with Ontario public health "Surveillance Form for Tick Identification". Encourage appropriate clothing and avoidance of tick habitats.
*Transmission of lyme disease only occurs when a tick has been attached and feeding for at least 24hrs. If in an area where Lyme disease has been document, skin checks every 24hrs are recommended.
**NBB is located in a low-risk area

Tinea Corporis/Ring Worm: Assess for source of infection and accompanying signs and symptoms. Apply topical anti-fungal such as clotrimazole (canesten), miconazole or tolnaftate to affected area as directed by package. For severe or recurrent infections consult MD for systemic antifungals. Assess cabin mates, family members and close friends for infection.

Tinea Cruris/Jock Itch/Crotch Rot: Assess for cause and accompanying signs and symptoms. Apply topical anti-fungal such as clotrimazole (canesten), miconazole or tolnaftate to affected area as directed by package. For severe or recurrent infections consult MD for systemic antifungals. Encourage patient to change out of sweaty or wet clothing as soon as possible and to wear cotton underwear if they possess it.

Tinea Pedis/Athletes Foot: Clean and dry feet if necessary. Administer OTC anti-fungal (Tinanctin, Micatin or Lotrimin) BID to affected area as per package directions. Encourage patient to keep feet clean and dry, wear cotton socks, wear sandals/flip flops in shower and not to share shoes with others. Assess skin for other areas of fungal infection.

Urinary Tract Infection: Assess for history of recurrent UTIs. Assess recent voiding history, flank pain and fever. Obtain mid-stream urine specimen, assess appearance of sample, conduct urinalysis with chem-9 strips, record results in patient chart. Do not discard urine, place in refrigerator to be sent to lab. Consult MD for C&S requisition and PO empiric antibiotics. If febrile treat with acetaminophen, do not administer NSAIDs due to potential renal involvement. Encourage patient to drink plenty of water (cranberry juice can be obtained if requested), void after sexual activity and ensure they are preforming personal hygiene appropriately.
*Evidence on the use of cranberry juice or supplements is mixed. However, it is not harmful and those who experience recurrent UTIs may find it helpful.

Unprotected Sex: Males should be offered STI testing, counselled in safer sex practices and given 2 condoms. For females see Pregnancy, suspected

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Vomiting/Nausea: Attempt to determine cause of nausea, the number of episodes of vomiting and any accompanying signs/symptoms. If nausea is suspected to be due to infective process, admit patient to health center and isolate. Be vigilant for additional cases, if ≥4 cases present, begin line list and contact public health. Treat nausea with pepto-bismol, ginger anti-emetic or dimenhydrinate PO (IM is also available), if patient is actively vomiting or continues to vomit after other interventions consult MD for SL ondansetron. Encourage hydration with water, Gatorade, gastro-lyte and ginger ale. **COVID screening pathway should be applied to these patients.**
*Homesickness can manifest as nausea/vomiting/upset stomach
**See Dehydration for nausea interventions suspected to be due to dehydration.
***See Fever for interventions for fever

Wound Infection, minor: Clean area with soap and water. Determine cause of wound. If wound is open, cleanse with sterile saline and apply fucidin ointment or cream. Cover with appropriate sterile dressing and secure. Patient should be assessed twice daily for worsening infection and dressing change as necessary. If infection worsens, even a small amount, consult MD. For closed infected wounds consult MD.

Candidiasis, oral: Assess for causative factors (medication, sexual activity). Consult MD for antifungal lozenge, buccal adhesive tablet or systemic PO antifungal prescription. Educate patient on proper use of inhaled corticosteroids or safer-sex practices as necessary.

Yeast Infection, vaginal: Assess history and potential causative factors. Offer Monistat 3-day treatment pack and instruct in use, give hydrocortisone or betamethasone cream if patient is experiencing a lot of swelling/discomfort. Consult MD for young campers and those experiencing a high degree of discomfort for PO Fluconazole. Encourage patient to change out of sweaty or wet clothing as soon as possible and to wear cotton underwear if they possess it.

Signature:  Date: June 11, 2022

Dr. Ashley Zaretsky CPSO #98075