MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

• Prescription medication must be in a container labeled by the pharmacist or prescriber.

• Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.

• An adult must bring the medication to the camp and give the medication to an adult staff member.

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME:_____ 2. DATE OF BIRTH ___/___/_____ Month/ Day/Year

3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:_____

4. EMERGENCY MEDICATION [ ] YES -If yes, see Section III below. [ ] NO

5. MEDICATION NAME:_____

6. DOSE:_____ 7. ROUTE:_____

8. TIME/FREQUENCY OF ADMINISTRATION:_____

9. IF PRN, FREQUENCY:_____

10. IF PRN, FOR WHAT SYMPTOMS:_____

11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD:_____

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is NOT TO EXCEED 1 YEAR.
12a. FROM ___/___/_____ Month Day Year

12b. TO ___/___/_____ Month Day Year

13. PRESCRIBER'S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

(TELEPHONE, FAX, ADDRESS, CITY,STATE, ZIPCODE)

14a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY) _____

14b. DATE: _____

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration if authorized as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication; otherwise it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE_____ 15b. DATE:_____

15c. HOME PHONE #_____ 15d. CELL PHONE # _____

15e. WORK PHONE #_____

III. AUTHORIZATION FOR SELF ADMINISTRATION / SELF CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers, insulin and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry. I consent that the child named above is able to self-administer the medication listed. I authorize self-administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE- authorizing self-administration

_____

16b. SELF CARRY EMERGENCY MEDICATION

(Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication

17a. SELF CARRY EMERGENCY MEDICATION

(Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication

17b. PARENT/GUARDIAN SIGNATURE authorizing self-administration:_____

17c. DATE_____