YMCA CAMP LETTS

Medication Administration Authorization

Camper Last Name:	**Camper First Name:**

I. CAMP OPERATOR

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.
- Non-prescription 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.

II. CAMP INFORMATION

Youth Camp Name: YMCA CAMP LETTS

Camp Address: 4003 Camp Letts Road, Edgewater, MD 21037

III. PRESCRIBER'S AUTHORIZATION

Camper Name:			Date of Birth:
Condition for which medication is being administered:	Emergency Medication:	YES	NO
Medication Name:	Dose:		Route:
Time/Frequency of Medication:	If PRN, frequency:		
If PRN, for what symptoms:			
Known side effects to child:			
Medication shall be administered: *(not to exceed 1 year)*	From:		To:
Prescribers Name/Title:			This space may be used for prescribers address stamp.
Telephone:	Fax:		
Address:			
City:	State:	Zip Code:	
Prescriber signature, or signature stamp: (Parent cannot sign) :			

IV. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff to administer the medication or supervise the camper in self administration if authorized as prescribed by the above 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 to communicate with the prescriber as allowed by HIPAA.

Parent/Guardian Signature:		Date:
Cell Phone:	Home Phone:	Work Phone:

V. AUTHORIZATION FOR SELF ADMINISTRATION AND 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. The child named above may self carry emergency medication if indicated below.

Prescribers Signature:	Self Carry Emergency Medication:			Date:
	Yes _____	No ____	Not an Emergency Med: _____	
Prescribers Signature:	Self Carry Emergency Medication:			Date:
	Yes _____	No ____	Not an Emergency Med: _____	

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS) - (410) 767-8417 - Toll Free 1-877-4MD-DHMH ext. 8417
DHMH-4758 (01/2015)