

MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

I. CAMP OPERATOR						
<p>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.</p> <ul style="list-style-type: none"> • 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. 						
II. CAMP INFORMATION						
YOUTH CAMP NAME						
PHYSICAL ADDRESS						
CITY		STATE		ZIPCODE		
III. PRESCRIBER'S AUTHORIZATION						
CHILD'S NAME				DATE OF BIRTH		
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:				EMERGENCY MEDICATION [] YES [] NO		
MEDICATION NAME		DOSE		ROUTE		
TIME/FREQUENCY OF ADMINISTRATION			IF PRN, FREQUENCY			
IF PRN, FOR WHAT SYMPTOMS						
KNOWN SIDE EFFECTS SPECIFIC TO CHILD						
MEDICATION SHALL BE ADMINISTERED <i>(NOT TO EXCEED 1 YEAR)</i>		FROM		TO		
PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp			
TELEPHONE		FAX				
ADDRESS						
CITY		STATE				ZIPCODE
PRESCRIBER'S SIGNATURE <i>(Parent cannot sign here)</i> <small><i>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</i></small>						DATE
IV. PARENT/GUARDIAN AUTHORIZATION						
<p>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.</p>						
PARENT/GUARDIAN SIGNATURE				DATE		
HOME PHONE #		CELL PHONE #		WORK PHONE #		
V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY						
<p>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.</p>						
PRESCRIBER'S SIGNATURE		SELF CARRY EMERGENCY MEDICATION (Check One) [] YES [] NO [] Not emergency medication		DATE		
PARENT/GUARDIAN'S SIGNATURE		SELF CARRY EMERGENCY MEDICATION (Check One) [] YES [] NO [] Not emergency medication		DATE		

