

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully in order for youth camp operators and staff members to supervise the camper to self-administer required medication. A new medication administration form must be completed at the beginning of each camp season, 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. Non-prescription 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

Section I. PRESCRIBER'S AUTHORIZATION							
1. CHILD'S NAME (First Middle Last)						2. DATE OF BIRTH (mm/dd/yyyy)	
3. MEDICATION SHALL BE ADMINISTERED During the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.						3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)
MedicationName	Condition being Treated. PRN Parameters	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry (Emerg Meds Only)	
1					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
					<i>Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No known side effects:</i>		
2					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
					<i>Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No known side effects:</i>		
3					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med	
					<i>Emergency Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No known side effects:</i>		
4. PRESCRIBER'S NAME/TITLE						This space may be used for the Prescriber's Address Stamp	
TELEPHONE		FAX					
ADDRESS							
CITY		STATE		ZIP CODE			
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)							
Section II. PARENT/GUARDIAN AUTHORIZATION							
I request the authorized youth camp operator or staff member to supervise the camper in self-administration 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 authorized individual 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							
6a. PARENT/GUARDIAN SIGNATURE				16b. DATE (mm/dd/yyyy)		16c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION	
6d. HOME PHONE#			6e. CELLPHONE#			6f. WORK PHONE#	
Section III. AUTHORIZATION FOR SELF-ADMINISTRATION/ SELF-CARRY							
I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator or a designated staff member. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."							
7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY			7b. DATE	8a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY			8b. DATE