

# MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

Kids Camp/Excursion Team Fax 301-948-6871  
Mountainside Fax 301-874-4659  
Ranch Fax 301-948-1602

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 authorized individual 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 <input type="checkbox"/> YES <i>-If yes, see Section III below.</i> <input type="checkbox"/> 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 <b>NOT TO EXCEED 1 YEAR.</b>		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. <b>PRESCRIBER'S SIGNATURE</b> ( <i>Parent/guardian cannot sign here</i> ) <small>(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)</small>				14b. <b>DATE</b>

## 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 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, as listed in 15c below, which may include the child, 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. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. 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 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 authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. <b>PRESCRIBER'S SIGNATURE</b> authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION ( <b>Check One</b> ) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	16c. <b>DATE</b>
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION ( <b>Check One</b> ) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A - Not emergency medication	17c. <b>DATE</b>

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I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM		DATE	
PLAN OF ACTION RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	HEALTH SUPERVISOR NOTIFIED	<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATION RECEIVED BY	PERSON'S SIGNATURE	DATE	

II. MEDICATION ADMINISTRATION RECORD	
Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.	

<b>Child's Name:</b>			<b>Date of Birth:</b>		
<b>Medication Name:</b>			<b>Dosage:</b>		
<b>Route:</b>			<b>Time(s) to Administer:</b>		
DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION

KEEP FOR 3 YEARS