

# 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"> <li>• Prescription medication must be in a container labeled by the pharmacist or prescriber.</li> <li>• Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.</li> <li>• An adult must bring the medication to the camp and give the medication to an adult staff member.</li> </ul>				
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		