MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

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

This form must be completed fully in order for youth camp operators and staff members to supervise 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 [ ] YES ***-If yes, see Section III below.*** [ ] 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 ***NOT TO EXCEED 1 YEAR***.	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. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	14b. DATE

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 (REQUIRED)

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. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE