# MEDICATION ADMINISTRATION AUTHORIZATION

## for Summer Camp Only



**Instructions to Parents/Guardians**

Page 2 of this Medication Administration Authorization form must be completed and signed by both you and the authorized Prescriber (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) for EVERY medication – whether over-the-counter (e.g., Advil) or prescription (e.g., Albuterol) – and each medication must have its own form. All over-the-counter medications must be in new, unopened containers.

**In Connecticut**, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/ guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure from camp.

**In Massachusetts,** all medications are administered in accordance with 105 CMR 430.160.

105 CMR 430.160(A)
Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over-the-counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)
Medication shall only be administered by the Health Supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)
When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

**Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.*

I have read the above and agree to abide by the requirements.

Signature of Parent/Guardian _____ Today's Date ___/__/___

# MEDICATION ADMINISTRATION AUTHORIZATION CAMP



*Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)*
**Only one medication per form, please.**

Name of Camper _____Date of Birth ___/___/___Age ___Today's Date ____/____/____

Medication Name _____Controlled Drug? ☐YES ☐NO

Dosage _____Method _____Time of Administration/Frequency_____

Specific Instructions for Medication Administration (e.g., on empty stomach, with milk, etc.) _____

_____Specify Precautions _____

Medication Administration: Start Date ___/___/____Stop Date ___/___/___Quantity Received _____

Expiration Date of Medications Received __/___/___Special Storage Requirements _____

Relevant Side Effects/Adverse Reactions _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain _____

Diagnosis (at parents discretion) _____

**Camper may self administer this medication** ☐YES ☐NO Prescriber's Initials _____

Prescriber's Name_____Business Telephone (___) _____

**Prescriber's Signature** _____Prescriber's Emergency Telephone (____) _____

Prescriber's Address _____Town/State/Zip _____

**Parent/Guardian Authorization**
I hereby authorize that medication be administered to my child as described and directed above and in accordance with CT State Statutes and Regulations and MA 105 CMR 430.160.

Name of Camp where medication administration will occur _____

Camp Program (if applicable) _____Dates Attending _____

Child's Name _____Address _____Town_____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other (explain): _____

Address _____Town _____Home Telephone (___) _____

Business Telephone (___) _____Emergency Telephone (____) _____

**Camper may self administer this medication** ☐ YES ☐ NO Parent's Initials _____

Signature of Parent/Guardian _____Today's Date ___/___/___

**Name of Camp Staff Receiving Written Authorization and Medication** _____

**Title/Position** _____**Signature (in ink)** _____