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 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 [ ] 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 (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. 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

Place Camper's
Picture Here

Epi-Pen Prevention Plan

Camper's Name: ______________________________ Date of Birth: ___________________

Counselor's Name: ______________________________

ALLERGY TO: ____

____

Asthmatic? Y/N) _______________ (Yes=Higher Risk for Severe Reaction)

Camp will:

- ☐ Have a Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis
  - ☐ administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to:____
- ☐ Havestafftrainedonindividualemergencyplans
- ☐ Camp staff will make every reasonable effort to prevent a camper's exposure to known allergens
- ☐ Other____

Parents will:

- ☐ Providepertinenthealthinformationtothecamp
- ☐ Provide Physician Authorization Forms and Action Plans
  - ☐ forcampermedicationandspecificactionsplansforemergency

care

- ☐ Current, non-expired medications
- ☐ Providesafesnackoptiontocamp/classroom
- ☐ Other:____
- ☐ Other:____
- ☐ Other:____

Camper will:

- ☐ Makeeveryefforttoavoidcontactwithallergen
- ☐ Alert nearest adult if suspect exposure to allergen
- ☐ Other

Notes:

Place Child's Picture Here

Management of Severe Allergic Reactions & Anaphylaxis

Student's Name: ____________________ **Date of Birth:** ____________

Teacher's Name: ____________________ **Room #:** ____________

ALLERGY TO: ____

____

Asthmatic? (Y/N) ____________ (Yes=Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	**Give This Medication** Epinephrine	 Antihistamine
If a food allergen is ingested or suspected bee sting, but *no symptoms*		
Mouth: itching, tingling, or swelling of lips, tongue mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat *: Tightening of throat, hoarseness, hacking cough		
Lung*: Shortness of breath, repetitive coughing, wheezing		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly:

EpiPen® or generic ____________ Epipen JR® or generic ____________ Auvi-Q ____________

Antihistamine: give ____

Other: give ____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

____________________	____________________
Doctor's Name	**Doctor's Phone Number**
Parent's Name	**Parent's Phone Number**
Emergency Contact 1 Name/Relationship	**Emergency Contact 1 Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

____________________	____________________
Parent Guardian's Signature/Date	**Doctor's Signature/Date**

The Banner School

Student Medications Policy and Procedure

Parents: please read the following and sign below. Return with Physician's Medication Form.

Policy

1. The Banner School will dispense to students only those medications deemed appropriate and prescribed by a licensed physician or nurse practitioner.
2. The Banner School will not dispense any medications or change any dosages or administration times unless authorized in writing by a licensed physician or nurse practitioner.
3. The Banner School does not assume any responsibility for medication that is not prescribed by a licensed physician or nurse practitioner and/or any medication in a student's possession of which the school is unaware.
4. Other than administering the dose at the correct time, The Banner School does not assume responsibility for why a drug is administered, for monitoring its action or any side effects or adverse reactions caused by the drug or combination of drugs that may be administered.
5. Any prescription and non-prescription medication needed on a field trip must have a completed medication order form. The order form and medication must be brought into the front office by a parent no later than five school days before the field trip.

Procedure

1. A Physician's Authorization for Prescription and Non-prescription Medication Form must be filled out and signed by a licensed physician or nurse practitioner for every prescription and non-prescription drug that a student may need to take during the course of the school day and on field trips. Parents are not to complete Part II, only a physician.
2. Parents must bring the completed Physician's Medication Form and the medicine in its original and properly labeled container to the school. The pharmacy label must match the Physician's Medication Form.
3. The delegating nurse will check the drug container and the Medication Form to be sure it is filled out completely. Any drug that is not in a properly labeled, original container, and any form that is illegible or not filled out completely **will be returned to the parent.** It is the responsibility of the parent to be sure the drug is in the appropriate container and to return the form to the physician so that it is filled out completely and correctly.
4. The drug container will be placed in a locked area. The Physician's Medication Form will be placed in the student's medication file.
5. The first dose of any newly prescribed medication must be given at home.
6. The school receptionist will dispense the drug to the student at the designated time. All doses administered are recorded on an administration sheet labeled with the student's name. If the dose is missed, the school receptionist will notify the parent.
7. When the prescribed number of doses have been administered, the school receptionist will indicate this on the administration form and return the empty drug container to the parent. All Physician's Medication Form and drug administration records are retained by the school.
8. All unused and/or unclaimed medication will be destroyed the day after the last day of school.

I understand and agree with the above policy and procedures so that my child can receive his/her medication at The Banner School.

Parent Signature____ **Date**___________