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

SEIZURE ACTION PLAN

Effective Date: _____

EPILEPSY FOUNDATION®

This child is being treated for a seizure disorder. This information below should assist you if a seizure occurs during childcare hours.

Child's Name	Date of Birth	
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	
Significant Medical History		

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Child response after a seizure:

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

Does the child need to leave the other children to recover? ☐ Yes ☐ No

If YES, describe process for returning child to interact with others:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this child is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic)seizure lasts longer than 5 minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child has a first-time seizure
- Child has breathing difficulties
- Child has a seizure in water

Treatment Protocol During Childcare Hours (include daily and emergency medications)

Emerg. Med.	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does child have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian 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**_____