MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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, and each time there is a change in dosage or time of administration of a medication.

Maryland Department of Health (MDH) Office of Healthy Homes and Communities (410) 767-8417 or 1-877-463-3464 ext. 78417 Draft Revision Date: 4/4/2018

- 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. Non prescription medication includes vitamins, homeophathic, and herbal medicines.
- An adult must bring the medication to the camp and give the medication to an adult staff member.

Section I. PRESCRIBER'S AUTHORIZATION												
1. CHILD'S NAME (First Middle Last)									2. DATE OF BIRTH (mm/dd/yyyy)			
3. MEDICATION SHALL BE ADMINISTERED 3a. FROM (mm/d									l/yyyy)	3b. TO (mm/dd/yyyy)		
durin	during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.											
Medication Name Condition Being Treated/PRN Parameters			arameters Dos	se	Route	Frequency	ОК	to Self-Administer	OK to Sel	f-Carry (Emerg Meds Only)		
1							□Y	es 🗆 No	□ Yes □	No □ Not emergency med		
					Emergency Medication: Yes No Known side effects:							
2							□Y	es 🗆 No	□ Yes □	No □ Not emergency med		
	Emergency Medication: Yes No Known side effects:											
3							□Y	es 🗆 No	□ Yes □	No □ Not emergency med		
3	Emergency Med				cation: 🗆 Yes 🗀 No Known side effects:							
<u>Д</u> Р	4. PRESCRIBER'S NAME/TITLE This space may be used for the Prescriber's Address Stamp											
	TELEPHONE FAX								3 Starrip			
	ADDRESS FAX											
CITY STATE ZIP CODE												
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)					51					E (mm/dd/yyyy)		
(original signature or signature stamp only) Section II. PARENT/GUARDIAN AUTHORIZATION												
to me	dical treatment for the child named a	ator, staff member or volunteer to administe above, including the administration of medic zed prescriber indicated on this form to com	ation at the facility. I	understand tha								
6a. PARENT/GUARDIAN SIGNATURE				6b. DATE (mm/dd/yyyy) 6c. INDIVIDUALS AUTHORIZED				TO PICK UP MEDICATION				
6d. HOME PHONE # 6e. CELL PHONE #				•	6f. WORK PHONE #							
Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)												
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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 all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."												
7a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY 7b. DATE				8a.	ta. PARENT/GUARDIAN'S SIGNATURE DR SELF-ADMINISTRATION/SELF-CARRY 8b. DATE					8b. DATE		

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This form must be completed fully in order for youth camp operators and staff members to adminter the required medication or for the camper to self-adminster medication. A new medication administration form must be completed at the beginning of each camp season, and each time there is a change in dosage or time of administration of a medication.

Maryland Department of Health (MDH) Office of Healthy Homes and Communities (410) 767-8417 or 1-877-4MD-DHMH ext. 8417 Draft Revision Date: 4/4/2018

- 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. Non prescription medication includes vitamins, homeophathic, and herbal medicines. - An adult must bring the medication to the camp and give the medication to an adult staff member,

Section I. PRESCRIBER'S AUTHORIZATION 1. CHILD'S NAME (First Middle Last) 2. DATE OF BIRTH (mm/dd/yyyy)										
3. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR. / / / / / / / / / / / / / / / / / / /										
uu	Medication Name	Condition Being Treated/PRI	· ·	ose	Route	Frequency		Self-Administer	OK to Se	f-Carry (Emerg Meds Only)
1				neraencu	Medication: 🗆 Yes 🗅	No Konyo sida i		S□No	☐ Yes □	No 🗆 Not emergency med
							47.20.000	- □ No	Тпус г	No □ Not emergency med
2			E	☐ Yes ☐ No Emergency Medication: ☐ Yes ☐ No Known side effects:					JE 10.	The difference of the differen
3							□Yes	i □ No	□Yes□	No □ Not emergency med
3			Eį	Emergency Medication: Yes No Known side effects:						
4				An Opto Angues			☐ Yes	□Ne	□Yes□	No □ Not emergency med
			Ei	nergency	Medication: G Yes O	No Known side e	effects:			
5			200					□No	□Yes□	No ☐ Not emergency med
				nergency	Medication: a Yes a	NO KNOWN SIDE E	52,000,000,000,000	□No	Inv. a	
6			Er	nergency	Medication: 🛭 Yes 🗗	No Known side e	Jan Grangelani balan	LI NO	Li res Li	No □ Not emergency med
							□Yes	□No	□Yes□	No □ Not emergency med
7			E	nergency	Medication: 🗅 Yes 🖽	No Known side e	effects;			
8							□Yes	□Ne	☐ Yes ☐	No to Not emergency med
Ü			En	nergency	Medication: 🗆 Yes 🙃	No Knawn side e	ffects:			
9				38 (S.23 (S) (S.23 (S) (S.23 (S) (S.23 (S.23 (S) (S.23 (S.23 (S) (S.23 (S.23 (S) (S) (S) (S.23 (S)			□Yes	□No	□Yes □	No 🗆 Not emergency med
			Eŋ.	nergency .	Medication: 🗆 Yes 🙃	No Known side e	1			
10			:: 5:		Medication: 🗈 Yes 🙃	No Vasuus sida a		□No	□Yes □	No 🗆 Not emergency med
			59	(ergency)	Wedicarion, 14 Tes 11	IVO KNOWII SIDE E		□No	Пуст П	No □ Not emergency med
11	Emergency Medic			Medication: 🗆 Yes 👊	No Known side e	Dies D	NO II NOT emergency med			
							□Yes	□No	□ Yes □	No 🗆 Not emergency med
12			En	nergency i	Medication: 🗅 Yes 🗅	No Known side e	ffects:			
13							☐ Yes	□№	□Yes □	No a Not emergency med
			En	ergency i	Medication: 🛭 Yes 🛱	No Known side ej	ffects:			
4. PRESCRIBER'S NAME/TITLE					Th	is space may	be used	for the Prescriber	¹s Address	s Stamp
TELEPHONE FAX ADDRESS										
CITY	CITY STATE ZIP CODE									
5a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)									5b. DATE	: (mm/dd/yyyy)
Section II. PARENT/GUARDIAN AUTHORIZATION I request the authorized youth camp operator, staff member or volunteer to administer the medication or to 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 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										
6a. P	5a. PARENT/GUARDIAN SIGNATURE 6b. DATE (mm/dd/yyyy) 6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION									
6d. H	66. HOME PHONE # 66. WORK PHONE PHON									
THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE 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.										
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7a. PRESCRIBER'S SIGNATURE 7b. DATE					8a. PARENT/GUARDIAN'S SIGNATURE 8b. DATE FOR SELF-ADMINISTRATION/SELF-CARRY					8b. DATE

MEDICATION ADMINISTRATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH) Center for Recreation and Community Environmental Health Services (CRCEHS) Office (410) 767-8417 Toll Free 1-877-463-3464 ext. 78417

I. FACILITY RECEIPT AND REVIEW											
MEDICAT	TION RECE	EIVED FROM				DATE					
PLAN OF	ACTION I	RECEIVED	[]YES []N	A/N [] C	HEALTH SUPERVIS	SOR NOTIFIED	[]YES []NO				
	TION RECE		PERSON'S SIGNA				DATE				
			II. MED	STRATION RECORD)						
separate i	medication	authorization for	ication shall be noted		rescription and p	rescription medication requires a the corresponding					
	ation record	d.		T							
Child's N				Date of Birth:							
Medicatio	on Name:				Dosage:						
Route:	1				Time(s) to Administer:						
DATE	TIME	DOSAGE	REACTION OBSE	RVED (IF ANY)	STAFF OR SELF ADMINISTERED		IVIDUAL WHO ADMINISTERED SED SELF-ADMINISTRATION				
				WEED FOR	VEADO						

KEEP FOR 3 YEARS

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