MEDICATION ADMINISTRATION AUTHORIZATION FORM

Howard County RECREATION & PARKS

This form must be completed fully in order for Howard County Recreation & Parks 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 adult 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. METHOD TO GIVE
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 Howard County Recreation & Parks to administer the medication or supervise the camper in self administration if authorized as prescribed by the above 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 adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA.

15a. PARENT/GUARDIAN SIGNATURE		15b. DATE
15c. HOME PHONE #	15d. CELL PHONE #	15e. 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, insulin 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 consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. If indicated below, the child named above may self carry emergency medication.

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

MEDICATION ADMINISTRATION FORM

Howard County RECREATION & PARKS

I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			PROGRAM NAME
PLAN OF ACTION RECEIVED ☐YES ☐NO ☐N/A		TR/ACCOMMODATIONS MANAGER NOTIFIED ☐YES ☐NO	
MEDICATION RECEIVED BY	QUANTITY	STAFF SIGNATURE	DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	ADMINISTERED OR SUPERVISED BY SIGNATURE

III. FINAL DISPOSITION OF MEDICATION

Child's Name:	**Date of Birth:**
Medication Name:	**Final Disposition:** **[ ] Returned** *(Complete Section A)* **[ ] Destroyed** *(Complete Section B)*

Section A

MEDICATION RETURNED TO (PRINT & SIGN NAME):	**DATE**
MEDICATION RETURNED BY (STAFF NAME & SIGNATURE)	**DATE**

Section B

The above indicated medication was not retrieved by the parent/guardian within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.

STAFF NAME & SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	**DATE**
NAME & SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	**DATE**