Authorization to Administer Medication to Minors at Camp

(To be completed by a parent/guardian.)

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| Recreational Camp Information | | | |
| Camp Name: | | City/Town: | |
| Child and Parent/Guardian Information | | | |
| Child’s Name: | | Age: | |
| Diagnosis (at parent/guardian discretion): | | Food/Drug Allergies: | |
| Parent/Guardian’s Name: | | | |
| Home Phone: | Emergency Phone: | Business Phone: | |
| Licensed Prescriber Information | | | |
| Name of Licensed Prescriber: | | | |
| Business Phone: | | Emergency Phone: | |
| Medication Information | | | |
| Name of Medication: | | | |
| Dose Given at Camp: | | Frequency: | |
| Route of Administration: | | Quantity Provided to Camp: | |
| Expiration Date of Medication Received: | | Special Storage Requirements: | |
| Special Directions (e.g., on empty stomach/with water): | | | |
| Possible Side Effects/Adverse Reactions: | | | |
| Additional -Medication Information (Add additional pages if more than 2 medications.) | | | |
| Name of Medication: | | | |
| Dose Given at Camp: | | Frequency: | |
| Route of Administration: | | Quantity Provided to Camp: | |
| Expiration Date of Medication Received: | | Special Storage Requirements: | |
| Special Directions (e.g., on empty stomach/with water): | | | |
| Possible Side Effects/Adverse Reactions: | | | |
| **Additional Medication Information** | | | |
| Other Medications Taken at Home (at parent/guardian discretion): | | | |
| Oral/Topical Medication Authorization: | | | |
| I hereby authorize the health care consultant or properly trained health care supervisor to administer, to my child, the oral/topical medication(s) listed above, in accordance with M.G.L. c. 94C and 105 CMR 430.160. **Please complete page # 2 where applicable.**  **□ Yes □ No □ Not Applicable** | | | |
| **Epinephrine Injection Authorization:** | | | |
| I hereby authorize my child to self-administer their prescribed epinephrine auto-injector, with approval of the health care consultant:  **□ Yes □ No □ Not Applicable**  I hereby authorize the designated healthcare supervisor who is a licensed healthcare professional authorized by their scope of practice to administer epinephrine auto-injectors, with approval of the health care consultant, to administer an epinephrine auto-injector to my child:  **□ Yes □ No □ Not Applicable**  I hereby authorize the designated healthcare supervisor who is NOT a licensed healthcare professional authorized by their scope of practice to administer epinephrine auto-injectors, but who is specifically trained in allergy awareness and epinephrine administration with approval of the health care consultant, to administer an epinephrine auto-injector to my child:  **□ Yes □ No □ Not Applicable** | | | |
| **Inhaler Authorization:** | | | |
| I hereby authorize my child to self-administer their prescribed inhaler, with approval of the health care consultant:  **□ Yes □ No □ Not Applicable** | | | |
| **Medication for Diabetes Care Authorization:** | | | |
| I hereby authorize my child to self-monitor and self-administer medication for diabetes care in the presence of the health care supervisor, and with approval of the health care consultant:  **□ Yes □ No □ Not Applicable**  I hereby authorize the designated healthcare supervisor who is a licensed healthcare professional authorized by their scope of practice to administer medications for diabetes care, with approval of the health care consultant, to administer diabetes medications to my child:  **□ Yes □ No □ Not Applicable** | | | |
| **Parent/Guardian Authorization** | | | |
| I have read and understand the authorizations that I have provided above for medications that are administered to my child at camp. I acknowledge receipt of the regulation references below that licensed camps must follow when administering medications at camp. | | | |
| Parent/Guardian Name: | | | |
| Signature of Parent/Guardian: | | | Date: |