Frederick County
Parks and Recreation

Camp Name:_____

Camp Location:_____

One form per site

MEDICATION AUTHORIZATION FORM

This form must be completed fully in order for the participant to self-administer the medication below. A new medication authorization form must be completed for **each** medication. If there is a change in dosage or time of administration of a medication, a new form must be completed.

- All medication, non prescription and prescription, will require Section A: Prescriber's Authorization, to be completed.
- Prescription medication must be in the original container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the program.

Section A: PRESCRIBER'S AUTHORIZATION (Completed by Health Care Provider)

Participant's Name:_____Date of Birth:_____

Condition for which medication is being self-administered:_____

Medication Name:_____Dose:_____Taken How:_____

Time/frequency of administration:_____If as needed, frequency:_____

If as needed, for what symptoms:_____

Possible side effects - Specify:_____

Medication shall be self-administered from:_____to_____

Month *I* Day / Year Month *I* Day *I* Year *(not to exceed 1 year)*

Prescriber's Name/Title:_____

Telephone:_____FAX:_____

Address:_____

City/State/Zip_____

This space may be used for the Prescriber's Address Stamp

Prescriber's Signature *(Parent cannot sign here)*_____Date_____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(May be authorized to self carry/self administer medication.)

Self carry/self administration of <u>emergency medication</u> noted above may be authorized by the prescriber.

Prescriber's Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

Section B: PARENT/GUARDIAN AUTHORIZATION

I authorize my child to self-administer the medication 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.

Parent/Guardian Signature:_____Date:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Section C: Completed by Frederick County Parks and Recreation Camp Staff

Medication was received from: :____Date:___________________

Plan of Action Received: □ Yes □ No □ N/A

Medication was received by: :____Date:___________________

Signature of Person Receiving Medication and Reviewing the Form

MEDICATION ADMINISTRATION RECORDS

Each self-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.

Participant's Name:	Date of Birth:
Medication Name:	Dose:
Taken How:	Time(s) of Administration:

DATE	TIME	DOSAGE	REACTIONS OBSERVED (IF ANY)	SIGNATURE