

## 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 authorization 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.

- 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.

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

| Section I. PRESCRIBER'S AUTHORIZATION   |  |                       |                       |   |  |   |                                       |
|---|--|-----------------------|-----------------------|---|--|---|---------------------------------------|
| 1. CHILD'S NAME (First Middle Last)   |  |                       |                       |   |  | 2. DATE OF BIRTH (mm/dd/yyyy)<br>____/____/____   |                                       |
| 3. MEDICATION SHALL BE ADMINISTERED<br>during the year in which this form is dated in 5b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.  |  |                       |                       |   |  | 3a. FROM (mm/dd/yyyy)<br>____/____/____   | 3b. TO (mm/dd/yyyy)<br>____/____/____ |
| Medication Name   | Condition Being Treated/PRN Parameters | Dose                  | Route                 | Frequency   | OK to Self-Administer                                    | OK to Self-Carry (Emerg Meds Only)  |                                       |
| 1   |  |                       |                       |   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |                                       |
|   |  |                       |                       |   |  |   |                                       |
| 2   |  |                       |                       |   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |                                       |
|   |  |                       |                       |   |  |   |                                       |
| 3   |  |                       |                       |   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not emergency med |                                       |
|   |  |                       |                       |   |  |   |                                       |
| 4. PRESCRIBER'S NAME/TITLE  |  |                       |                       | This space may be used for the Prescriber's Address Stamp             |  |   |                                       |
| TELEPHONE   |  | FAX                   |                       |   |  |   |                                       |
| ADDRESS   |  |                       |                       |   |  |   |                                       |
| CITY  |  | STATE                 | ZIP CODE              |   |  |   |                                       |
| 5a. PRESCRIBER'S SIGNATURE (Parent/Guardian cannot sign here)<br>(original signature or signature stamp only – cannot be digital)   |  |                       |                       |   |  | 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. 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 LISTED IN SECTION I 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 checks as "OK to self-administer and self-carry."  |  |                       |                       |   |  |   |                                       |
| 7a. PRESCRIBER'S SIGNATURE<br>FOR SELF-ADMINISTRATION/SELF-CARRY  |  | 7b. DATE (mm/dd/yyyy) |                       | 8a. PARENT/GUARDIAN'S SIGNATURE<br>FOR SELF-ADMINISTRATION/SELF-CARRY |  | 8b. DATE (mm/dd/yyyy)   |                                       |