

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Silver Stars Gymnastics
Silver Spring-2701 Pittman Dr., Silver Spring, Md. 20910
Fax 301-589-1717
Bowie-14201 Woodcliff Ct., Bowie, Md. 20720
Fax 301-352-8414

I. CAMP OPERATOR

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, 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.

II. CAMP INFORMATION

YOUTH CAMP NAME

PHYSICAL ADDRESS

CITY

STATE

ZIPCODE

III. PRESCRIBER'S AUTHORIZATION

CHILD'S NAME

DATE OF BIRTH

CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:

EMERGENCY MEDICATION

YES NO

MEDICATION NAME

DOSE

ROUTE

TIME/FREQUENCY OF ADMINISTRATION

IF PRN, FREQUENCY

IF PRN, FOR WHAT SYMPTOMS

KNOWN SIDE EFFECTS SPECIFIC TO CHILD

MEDICATION SHALL BE ADMINISTERED

FROM

TO

(NOT TO EXCEED 1 YEAR)

PRESCRIBER'S NAME/TITLE

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

TELEPHONE

FAX

ADDRESS

CITY

STATE

ZIPCODE

PRESCRIBER'S SIGNATURE (*Parent cannot sign here*)

DATE

(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)

IV. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/staff 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.

PARENT/GUARDIAN SIGNATURE

DATE

HOME PHONE #

CELL PHONE #

WORK PHONE #

V. AUTHORIZATION FOR SELF ADMINISTRATION AND 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. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE

SELF CARRY EMERGENCY MEDICATION (Check One)

DATE

YES NO Not emergency medication

PARENT/GUARDIAN'S SIGNATURE

SELF CARRY EMERGENCY MEDICATION (Check One)

DATE

YES NO Not emergency medication