MARTHA'S VINEYARD
BOYS & GIRLS CLUB

# Authorization to Administer Medication to a Camper

| Camper and Parent/Guardian Information | |
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| Camper's Name: | |
| Age: | Food/Drug Allergies: |
| Diagnosis (at parent/guardian discretion): | |
| Parent/Guardian's Name: | |
| Home Phone: | Cell Phone: |
| Emergency Contact Name: | Telephone: |
| **Licensed Prescriber Information** | |
| Name of Licensed Prescriber: | |
| Business Phone: | Emergency Phone: |
| **Medication Information 1** | |
| Name of Medication: | |
| Dose given at camp: | Route of Administration: |
| Frequency: | Date Ordered: |
| Duration of Order: | Quantity Received: |
| Expiration date of Medication Received: | |
| Special Storage Requirements: | |
| Special Directions (e.g., on empty stomach/with water): | |
| Special Precautions: | |
| Possible Side Effects/Adverse Reactions: | |
| Other medications (at parent/guardian discretion): | |
| Location where medication administration will occur: | |
| **Medication Information 2** | |
| Name of Medication: | |
| Dose given at camp: | Route of Administration: |
| Frequency: | Date Ordered: |

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|---|---|
| Duration of Order: | Quantity Received: |

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| Expiration date of Medication Received: |
| Special Storage Requirements: |
| Special Directions (e.g., on empty stomach/with water): |
| Special Precautions: |
| Possible Side Effects/Adverse Reactions: |
| Other medications (at parent/guardian discretion): |
| Location where medication administration will occur: |

## Authorization Information

I hereby authorize the health care consultant or properly trained health care supervisor at _____
(name of camp)
to administer, to my child, _____ the medication(s) listed above, in accordance with 105 CMR
(name of camper)
430.160(C) and 105 CMR 430.160(D) [see below].

**If above listed medication includes epinephrine injection system:**

I hereby authorize my child to self-administer , with approval of the health care consultant

☐ Yes ☐ No ☐ Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer

☐ Yes ☐ No ☐ Not Applicable

**If above listed medication includes insulin for diabetic management:**

I hereby authorize my child to self-administer , with approval of the health care consultant

☐ Yes ☐ No ☐ Not Applicable

| | |
|---|---|
| Signature of Parent/Guardian: | Date: |

** **Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.