



# MARTHA'S VINEYARD BOYS & GIRLS CLUB

## Authorization to Administer Medication to a Camper

### Camper and Parent/Guardian Information

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:

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:	
<b>Authorization Information</b>	
<p>I hereby authorize the health care consultant or properly trained health care supervisor at _____ (name of camp) to administer, to my child, _____ (name of camper) the medication(s) listed above, in accordance with 105 CMR 430.160(C) and 105 CMR 430.160(D) [see below].</p>	
<p><b>If above listed medication includes epinephrine injection system:</b></p> <p>I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p>I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><b>If above listed medication includes insulin for diabetic management:</b></p> <p>I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p>	
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.