MONTAGUE PARKS & RECREATION DEPARTMENT

SUMMER CAMP MEDICATION ADMINISTRATION PERMISSION FORM

In accordance with 105 CMR 430.160 (C) and 105 CMR 430.160 (D), the camp's health care supervisor must have a medication order from a physician, dentist, nurse practitioner, or physician assistant in order to administer any medication, whether it is a prescription drug or an over-the-counter medication.

PART 1 – TO BE COMPLETED IN FULL BY CAMPER'S HEALTH CARE PROVIDER

Please complete this form if the child below **must** take medication during camp hours and it cannot be given at home.

NAME of CAMPER: ____ D/O/B: _____________________

Diagnosis: ____

Medication: ____

Dosage: _________________________________ Route of administration: _____________________________

Frequency: ______________________________ Time(s) of administration: ____________________________

Date of Order: ____________________________ Discontinuation Date: _______________________________

Other medications taken by the camper: ____

Any special instructions: ____

Possible side effects: ____

Can medication be omitted on field trips? _________ YES __________ NO

If this is an emergency medication (i.e. inhaler, EpiPen), has the child been instructed to self-administer and may s/he do so if the camp's health care consultant determines it is safe and appropriate? _________ YES _________ NO

DATE: _____________________ Prescriber signature: ____

Printed Name of Prescriber______________________________________

PART 2 – TO BE COMPLETED BY THE CAMPER'S PARENT/GUARDIAN

All prescription and over-the-counter medications must be in the original pharmacy container, clearly labeled with the child's name, the date, the medication name, the medication strength, the dosage/frequency of the medication, and the name of the prescriber. Most pharmacies will provide a second labeled container, if requested, for camp use. An adult must bring all medications to the Parks & Recreation Office, and no more than a 30-day supply may be stored at the office. Please remind your child s/he is responsible for going to the office at the appropriate time.

Note: If camp is dismissed for any reason before the regularly scheduled time for your child's medication, the medication will not be given at camp. You will be responsible for medication administration on those days.

I, the undersigned, give permission to the MPRD's health care supervisor or designee to:

____YES ____ NO Administer the above medication to my child or to supervise my child in taking the above medication.

____YES ____ NO Share information relevant to the medication when necessary for my child's health and safety.

____YES ____ NO Contact the prescriber's office to confirm or clarify medication instructions.

____YES ____ NO Allow my child to self-administer the medication if the camp's health care consultant determines it is safe and appropriate.

DATE: _______________________ Parent/Guardian signature: ____

Printed name of Parent/Guardian_____________________________________

AT THE END OF TREATMENT OR SCHOOL YEAR ANY UNCLAIMED MEDICATION WILL BE DESTROYED