

Health/Medication Authorization Form

Complete this form for any individual with medical/behavioral concerns, medication (prescription/non-prescription), and/or emergency medical devices.

I. GENERAL INFORMATION

Camper Full Name: _____

Parent/Guardian: _____

Phone: _____

II. MEDICATION - PRESCRIBER'S AUTHORIZATION

Individuals **MUST** be able to name and recognize, know the proper dosage and how to administer their medication.

Name of Medication (includes emergency medical devices): _____

Reason for medication: _____

Emergency Medication: _____

YES (see section IV)

NO

Medication Dose/Frequency: _____

Possible side effects of medication: _____

MEDICATION TAKEN AT HOME: Parent Signature: _____

Date: _____

MEDICATION TAKEN DURING PROGRAM HOURS: _____

Physician Stamp: _____

Physician Name: _____

Physician Address: _____

Prescriber's Signature: _____

Date: _____

III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized camp director/staff to 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 distribution 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 within ONE WEEK of the camper leaving camp. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I agree to release the BCPA and its agents from any and all liability arising as a result of this waiver.

Printed Name (Parent/Guardian): _____

Signature (Parent/Guardian): _____

Date _____

IV. AUTHORIZATION FOR SELF-CARRY

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medical devices such as inhalers or epinephrine. Both the prescriber and the parent/guardian must consent to self-administration by signing below, however camp operators are not required to permit self-administration or 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 camp operator/staff member. If indicated below, the child named above may self-carry emergency medication. I agree to release the BCPA and its agents from any and all liability arising as a result of this waiver.

Prescriber's Signature: _____

Self-Carry

Do NOT Self-Carry

N/A (non-emergency)

Parent/Guardian Signature: _____

Self-Carry

Do NOT Self-Carry

N/A (non-emergency)

V. ALLERGY/OTHER INFORMATION

Does the individual have any allergies staff should be aware of?

None

Food

Medication

Environmental (pollen, poison ivy, etc.)

Describe Allergy: _____

Reaction Level: _____

Mild

Moderate

Severe

Required Treatment: _____

Are there any health concerns staff should be aware of?

No

Yes

Please Explain: _____

Are there any physical, psychiatric, behavioral, emotional, or developmental concerns staff should be aware of?

No

Yes

Please Explain: _____