MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland

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, 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. Non prescription 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.

### Section I. PRESCRIBER’S AUTHORIZATION

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Condition Being Treated/PRN Parameters</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>OK to Self-Administer</th>
<th>OK to Self-Carry (Emerg Meds Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No</td>
<td>Yes □ No □ Not emergency med</td>
</tr>
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<td>Known side effects: Yes □ No</td>
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<tr>
<td>2</td>
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<td></td>
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<td></td>
<td>Yes □ No</td>
<td>Yes □ No □ Not emergency med</td>
</tr>
<tr>
<td>3</td>
<td></td>
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<td></td>
<td>Yes □ No</td>
<td>Yes □ No □ Not emergency med</td>
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<td>Emergency Medication: □ Yes □ No</td>
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<td>Known side effects: Yes □ No</td>
</tr>
</tbody>
</table>

### Section II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized 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 authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

### Section III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if any medications in the asthma action plan above are approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

### Form Details

- **PRESCRIBER’S SIGNATURE**
- **DATE**
- **PARENT/GUARDIAN’S SIGNATURE**
- **DATE**

**MEDICATION ADMINISTRATION AUTHORIZATION FORM for Youth Camps in Maryland**

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-463-3464 ext. 78417
Draft Revision Date: 4/4/2018

MDH-4758-A (12/2019)
**Section I. ASTHMA ACTION PLAN**

**GREEN ZONE - DOING WELL**

You have **ALL** of these:

- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- If known, peak flow greater than ____ (80% personal best)

**Exercise Zone**

- **Rescue Medication**

**YELLOW ZONE - GETTING WORSE**

You have **ANY** of these:

- Some problems breathing
- Wheezing, noisy breathing
- Tight chest
- Cough or cold symptoms
- Shortness of breath
- Other: __________________________

If known, peak flow between ____ and _____ (50% to 79% personal best)

**RED ZONE - MEDICAL ALERT/DANGER**

You have **ANY** of these:

- Breathing hard and fast
- Lips or fingernails are blue
- Trouble walking or talking
- Medicine is not helping (15-20 mins?)
- Other: __________________________

If known, peak flow below _____ (0% to 49% personal best)
I authorize self-administration of all the medications listed in Section I: Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

I authorize self-administration of all of the medications listed in Section I: Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized 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 authorized individual must pick up the medication; otherwise, it will be discarded. I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in Section I: Asthma Action Plan above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I: Asthma Action Plan, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

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