

Meadowcroft Day Camp Authorization to ADMINISTER MEDICATION to a CAMPER

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To be completed by parent/guardian and countersigned by the Health Care Consultant

Name of Camper: _____ Age: _____

Food/Drug Allergies: _____

Diagnosis: (at parents discretion) _____

Name of Licensed Prescriber: _____ Business Telephone: _____

Parent/Guardian Name: _____

Home Telephone: _____ Business Telephone: _____

Emergency Telephone: _____ Cellular Telephone: _____

Name of Medication: _____ Frequency: _____

Date Ordered: _____ Dose given at camp: _____

Duration of Order: _____ Route of Administration: _____

Quantity Received: _____ Expiration date of Medications Received: _____

Special Storage Requirements: _____

Specific Directions ((e.g., on empty stomach/with water) Specific Precautions: _____

Possible Side Effects / Adverse Reactions: _____

Other medications (at parents discretion): _____

Location where medication administration will occur: _____

I hereby authorize Meadowcroft Day Camp to administer, to my child, _____

(NAME OF CHILD)

Medication prescribed for campers MUST be brought from home and shall ONLY be administered if it is from the ORIGINAL CONTAINER.

Parent/Guardian Signature: _____ Date: _____

Health Consultant Signature: _____ Date: _____

ALL MEDICATION WILL BE ADMINISTERED ACCORDING TO MASSACHUSETTS STATE LAW:
105 CMR 430.160(A) 105 CMR 430.160(C) 105 CMR 430.160(0)