M-NCPPC, Department of Parks and Recreation, Prince George's County

Health/Medication Authorization Form

Complete this form for any individual with medical/behavioral concerns, medication (prescription/non-prescription), and/or emergency medical devices. This form must be completed fully. A new health/medication form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or distribution of medicine. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription medication must be in the original container with the instructions for use. Non-prescription medication includes over-the-counter, vitamins, homeopathic, and herbal medicines. An adult must bring the medication to camp and give the medication to the adult camp operator/camp staff on site. Program staff will verify in writing the amount of medications they have accepted for an individual (up to 2 weeks).

I. GENERAL INFORMATION

Site name/program: _____ PARKS DIRECT Activity #: _____

Participant Name: _____

II. MEDICATION – PRESCRIBER'S AUTHORIZATION

A separate form must be completed for each medication the individual may need during camp hours. Individuals MUST be able to name and recognize, know the proper dosage and how to administer their medication. The first dose of any new medication must be taken 24 hours prior to attending an M-NCPPC program. Please note: the M-NCPPC medication policy differs for Day Camps and Playground/Teen Sites. Individuals enrolled in a Day Camp may self-administer a prescription, including emergency medical devices and over the counter medications during day camp hours; however, ONLY emergency medical devices can be self-administered at Playground/Teen Sites and individuals are required to self-carry.

Name of Medication (includes emergency medical devices): _____

Reason for medication(s): _____ Emergency Medication: ☐ YES (see section IV) ☐ NO

Medication Dose/Frequency: _____ If PRN, what symptoms? _____

Possible side effects of medication(s): _____

☐ MEDICATION TAKEN AT HOME: Parent Signature: _____ Date: _____

☐ MEDICATION TAKEN DURING PROGRAM HOURS

Physician Name & Title (printed): _____

Physician address: _____

Prescriber's Signature: _____ Date: _____

Physician Stamp

III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator/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 HIPPAA. I agree to release the M-NCPPC 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 youth camp operator/staff member. If indicated below, the child named above may self-carry emergency medication. I agree to release the M-NCPPC 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's 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: _____

Date of Last Seizure (if applicable): _____