Christodora-Manice Education Center
Summer 2010

Authorization to Administer Medication to a Student

(To be completed by parent/guardian. This form must be given to a staff member of the Christodora-Manice Education Center.)

***Please note that you **must** submit all medications, prescription or over the counter, in the original containers bearing the directions for use and the pharmacy and patient information!*

Student Name____

Name of Medication #1 ____________________ Dosage__________ Frequency__________
Route of Administration: Oral Topical Other____________________
Quantity given to camp__________________ Expiration date of medications received__________
Special storage requirements: No Yes Describe____________________
Specific directions______________________________
Specific precautions______________________________
Possible side effects/adverse reactions________________________

Name of Medication #2 ____________________ Dosage__________ Frequency__________
Route of Administration: Oral Topical Other____________________
Quantity given to camp__________________ Expiration date of medications received__________
Special storage requirements: No Yes Describe____________________
Specific directions______________________________
Specific precautions______________________________
Possible side effects/adverse reactions________________________

Name of Medication #3 ____________________ Dosage__________ Frequency__________
Route of Administration: Oral Topical Other____________________
Quantity given to camp__________________ Expiration date of medications received__________
Special storage requirements: No Yes Describe____________________
Specific directions______________________________
Specific precautions______________________________
Possible side effects/adverse reactions________________________

Name of Medication #4 ____________________ Dosage__________ Frequency__________
Route of Administration: Oral Topical Other____________________
Quantity given to camp__________________ Expiration date of medications received__________
Special storage requirements: No Yes Describe____________________
Specific directions______________________________
Specific precautions______________________________
Possible side effects/adverse reactions________________________

-- Please attach additional pages, if necessary.

I understand that Christodora-Manice Education Center does not assume responsibility for any medication you have not appropriately listed. I also understand that I must report any non-prescription medications my student is not permitted to take. I hereby authorize Christodora-Manice Education Center to administer to my student, _________________________, the medication(s) listed above, in accordance with 105 CMR 430.160.

105 CMR 430. 160 (A) Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430. 160 (C) Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. **Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.**

105 CMR 430. 160 (D) When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

Parent/Guardian Signature: ____Date________________

****If your child carries an inhaler for asthma and/or an epi-pen for allergies, please read and sign below.**

I hereby authorize my child, ____________________________, to carry and administer his/her own metered dose inhaler(s) and/or epi-pen(s) as currently prescribed by a **licensed health care professional.**

Parent/Guardian Signature: ____Date________________