Authorization to Administer Medication

Individual Health Care Plan

Updated: 8/26/14 v2.0

Dates of Attendance: _____

Mailing Address: Cedardale Health & Fitness
931 Boston Road
Haverhill MA 01935

CHILD'S INFORMATION:

Gender: ☐ Male ☐ Female

Name: _____ Birth Date: _____ Age: _____
Last *First* *Middle Initial*

Food/Drug allergy: _____

1ST PARENT/GUARDIAN TO BE CONTACTED:

Name: _____ Cell Phone: _____

Home Phone: _____ Business Phone: _____

2ND PARENT/GUARDIAN TO BE CONTACTED:

Name: _____ Cell Phone: _____

Home Phone: _____ Business Phone: _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (In order to be contacted)

Name: _____ Cell Phone: _____ Relation to child: _____

MEDICATION:

Name of Licensed Prescriber: _____ Business Phone: _____

Emergency Phone: _____

Name of Medication: _____ Dose Given: _____ Rout of Administration: _____

Frequency: _____ Date Ordered: _____ Duration of Order: _____ Quantity received: _____

Expiration Date of Medications Received: _____ Special Storage Requirements: _____

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

Special Precautions: _____

Possible Side Effects: _____

Other Medications (at parent's discretion): _____

Location Where Medication Administration Will Occur: _____

Date of first dose (first dose of a medication will never be given at the program): _____

Medication prescribed for children 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 children shall be kept in the original containers containing the original label, which shall include the directions.

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the program. 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. 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 of guardian.

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.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

*Health Care Consultant - A designated Massachusetts licensed physician, nurse practitioner or physician assistant with pediatric training

I hereby authorize: _____ to administer, to my child, _____ the medication(s) in
Name of Program *Name of Child*
accordance with the regulations listed above.

Parent/Guardian Signature: _____ Date: _____