



Camp Howe  
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413-268-7635

**AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO A CAMPER**

(To be completed by Doctor – One form per each medication)

Name of Child: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

City/Town Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Food/Drug Allergies: \_\_\_\_\_

**Information on Prescribed Medication**

Name of Medication: \_\_\_\_\_

Condition who which medication is being given for: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Dose given at camp: \_\_\_\_\_

Frequency: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_

Is this a controlled Medication: \_\_\_\_\_

Special Storage Requirements: \_\_\_\_\_

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

Specific Precautions \_\_\_\_\_

Possible Side Effects/Adverse Reactions and Management: \_\_\_\_\_

Physician or Dentist's Name \_\_\_\_\_

Street Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Phone No. \_\_\_\_\_

Physician or Dentist's Signature \_\_\_\_\_

Date: \_\_\_\_\_

**AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO A CAMPER**  
(To be completed by Parent/ Guardian)

I hereby request that the medication ordered by the physician/dentist for my child \_\_\_\_\_, be administered in accordance with 105 CMR 430.160.

I understand that I must supply the Camp Howe with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Print Name of Parent/Guardian \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to child \_\_\_\_\_

Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Phone Number with Area Code \_\_\_\_\_

**105 CMR 430.160(~)**

*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 (he directions for use.*

**105 CMR 430.160(C1)**

*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 camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under (lie 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/guardian.*

**105 CMR 430. 160(~)**

*When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, if 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.