

# AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Matt Noone Baseball Summer Camp

This form should be filled out if your child will be taking medication while at camp.

(To be completed by parent/guardian and countersigned by Matt Noone Baseball LLC health-care consultant)

NAME OF CAMPER:	D.O.B.:
FOOD/DRUG ALLERGIES:	AGE:
DIAGNOSIS (AT PARENTS' DISCRETION):	
PARENT/GUARDIAN NAME:	
HOME PHONE:	CELL PHONE:
BUSINESS PHONE:	EMERGENCY PHONE:
NAME OF LICENSED PERSCRIBER:	
BUSINESS PHONE:	EMERGENCY PHONE:
NAME OF MEDICATION:	DOSE GIVEN AT CAMP:
ROUTE OF ADMINISTRATION:	FREQUENCY:
DATE ORDERED:	DURATION OF ORDER:
QUANTITY RECEIVED:	EXPIRATION DATE OF MEDICATIONS RECEIVED:
SPECIAL STORAGE REQUIREMENTS:	
SPECIAL 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 the properly trained health care supervisor at the Matt Noone Baseball Summer Camp at Babson College to administer to my child, \_\_\_\_\_, the medications listed above, in accordance with 105 CMR 430.160(C) and 105 CMR 430.160 (D).

If above listed medication includes epinephrine injection system:

I hereby authorize my child to self-administer, with approval of the health care consultant. ☐Yes ☐No ☐Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer.

☐Yes ☐No ☐Not Applicable

If the above listed medication includes insulin for diabetic management:

I hereby authorize my child to self-administer, with approval of the health care consultant. ☐Yes ☐No ☐Not Applicable

If the above listed medication includes self-administering rescue inhalers (i.e. albuterol)

I hereby authorize my child to self-administer, with approval of the health care consultant. ☐Yes ☐No ☐Not Applicable

## 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. Medication prescribed for campers brought from home shall be administered only if it is from the original container, there is written permission from the parent/guardian, and the health-care consultant approves in writing the administration of the medication.

## 105 CMR 430.160(0)

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.

SIGNATURE OF PARENT/GUARDIAN:	DATE:
PHONE:	