Medication Dispersal Authorization Form

To be completed by participant or parent/ guardian (if under 18 years of age)

I hereby authorize_____ to administer, to my child, _____ 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. 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 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/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.

*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.

Please Print clearly. Complete all information and return

Food/Drug Allergies: _____Diagnosis (at parents discretion) :_____

Name of medication: _____ Dose given at BSU program:_____

Name of medication: _____ Dose given at BSU program:_____

Name of medication: _____ Dose given at BSU program:_____

Route of administration :_____ Frequency: _____ Date ordered:_____

Quantity received:_____ Expiration date of medications received: _____

Special storage requirements _____

Specific directions (e.g. on empty stomach/with water_____

Specific precautions _____Possible side effects/reactions _____

Other medications (at parents' directions):_____

Parent /Guardian Signature_____ Date_____