MEDICATION ADMINISTRATION AUTHORIZATION FORM for Girl Scouts of the Chesapeake Bay

The medication authorization form is required if your camper is bringing ANY medication to camp. This includes prescription medication, vitamins and daily over-the-counter medications. Note that a medical professional's signature is required on line 7a./b. to bring medication to camp.

NOT BRINGING MEDICATION TO CAMP	
1. CHILD'S NAME (First Middle Last)	**2. DATE OF BIRTH** (mm/dd/yyyy)
I verify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand the requirements to bring medication to camp, and I will not be bringing any medication to camp.	
3.a. GUARDIAN NAME	**3.**b. GUARDIAN SIGNATURE
4.. DATE (mm/dd/yyyy)	

BRINGING MEDICATION TO CAMP						
Section I. PRESCRIBER'S AUTHORIZATION						
1. CHILD'S NAME (First Middle Last)				**2. DATE OF BIRTH** (mm/dd/yyyy)		
3. MEDICATION SHALL BE ADMINISTERED during the dates specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.				3a. FROM (mm/dd/yyyy)	3b. TO (mm/dd/yyyy)	
4. Medication Name		Condition Being Treated/PRN Parameters	Dose	Route	Frequency	OK to Self-Administer
1						☐Yes ☐No
			Emergency Medication: ☐Yes ☐No Known side effects:			
2						☐Yes ☐No
			Emergency Medication: ☐Yes ☐No Known side effects:			
3						☐Yes ☐No
			Emergency Medication: ☐Yes ☐No Known side effects:			
6. PRESCRIBER'S NAME/TITLE						This space may be used for the Prescriber's Address Stamp
TELEPHONE				FAX		
ADDRESS						
CITY		STATE		ZIPCODE		

NOT COMPLETE. MUST COMPLETE SECOND PAGE

7a. PRESCRIBER'S SIGNATURE (Parent/Guardian cannot sign here.) (Original signature or signature stamp only)	7b. DATE (mm/dd/yyyy)

Brining Medication to Camp
Section II. GUARDIAN'S AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or supervise the camper in self-administration as prescribed by the above authorized prescriber. I verify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded.

I authorize camp personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

I understand that prescription medication must be in a container labeled by the pharmacist or prescriber, and nonprescription medication must be in the original container with the instructions for use.

I agree that all individuals authorized to pick up the camper are authorized to pick up any medications.

I authorize self-administration of all of the medications listed in Section I above that are checked as "OK to self-administer" or "OK to self-administer and self-carry" for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated in Section I, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

1a. GUARDIAN NAME	1b. GUARDIAN SIGNATURE
2c. DATE (mm/dd/yyyy)	2d. CELL PHONE #