SYRACUSE UNIVERSITY SUMMER CAMP

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a summer camp chooses to administer medication, the Onondaga County Department of Health requires an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for camp personnel to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber, or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER DATE _____/_____/_____

Name of Camper_____Date of Birth_____/_____/_____
Street Address_____City_____State_____
Condition for which medication is being administered during camp hours_____

Medication (Name, dose, method of administration) _____Is this a controlled drug? Y N

Times of Administration: Breakfast Lunch Dinner Bedtime As Needed Other:_____
Medication shall be administered from ____/___/____ to ____/___/____
Relevant side effects to be observed, if any _____
If there are side effects, plan for management _____
Allergies, reaction to, or negative interaction with food or drugs? If YES, explain/list_____

Authorization by <u>Prescriber</u> for administration of above medication:

Prescriber's Name_____Phone(____) _____

Address_____City_____State_____

Prescriber's Signature_____Date_____

Authorization by Parent/Guardian for the administration of the above medication:

I have legal authority to consent to medication administration for the camper named above, including the administration of medication. I hereby request that the above medication, ordered by the authorized prescriber for my child be administered by the camp personnel designated by the Camp director. I understand that I must supply the summer camp with the prescribed medication in the original container and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order/camp. I agree to indemnify and hold harmless the Summer Camp Program Staff, Syracuse University, its Board of Trustees, officers and employees against any claims that may arise relating to my child's self-administration of medication.

Parent/Guardian Name_____Relationship_____
Address_____City_____State_____Phone (___) _____
Parent/Guardian's Signature_____Date_____

Authorization/Approval for Self-Administration of above medication:

<u>Self-administration</u> of medication may be authorized by the prescriber and parent/guardian approval for only <u>asthma medication and epi-pens.</u> SU camp personnel may witness the self-administration.

Prescriber's authorization for self-administration: YES NO _____
Signature Date

Parent/Guardian's authorization for self-administration: YES NO _____
Signature Date