General Medication and Self-Carry Medication Medical Provider Authorization Form

This authorization is for any youth program attendees that need prescribed medication dispensed during youth program hours or for self-carry medications such as asthma medication, epinephrine, etc.

Prescription medications to be self-administered during youth programs must be in the original pharmacy labeled container. Over the counter medication must be in the original container with the child's name affixed to the container.

To be completed by the child/ward's parent(s)/guardian(s)

Child/Ward's Name: _____ Birth Date: _____
Allergies:_____

To be completed by the youth program attendee's medical provider (physician, physician assistant with prescriptive authority, or advanced practice registered nurse with prescriptive authority)

Prescriber's Printed Name: _____

Office Address: _____Phone Number: _____

Medication Name: _____

Purpose of Medication/Diagnosis: _____

Dosage: _____

Time of Administration:_____Route:_____

Appearance of Medication (Tablet, Liquid, Capsule): _____

If medication is to be given "as needed", describe circumstances: _____
_____

How soon can it be repeated? _____

Is child authorized to medicate themself? _____

Length of time this treatment is recommended: _____

List significant side effects: _____

Other Medication child is receiving: _____

Is it necessary for this medication to be administered during the youth program day in order to allow the child to attend the youth program or to address the child's medical condition that may arise at the youth program?
_____

Does medication qualify for or is part of an emergency action plan? _____Please provide a copy (i.e., Asthma Action plan, Food Allergy Action Plan, Seizure Action Plan, Diabetes Medical Management Plan) and include any and all steps that should be taken by camp staff in the event of emerging symptoms.

I hereby certify that the above-named youth program attendee has been instructed in the use and self-administration of the above- described medication. Furthermore, I hereby assert that the child/ward understands the need for the medication and the necessity to report to youth program staff any unusual side effects.

_____ _____
Date Physician, Physician Assistant, or Advanced Practice Registered Nurse Name

_____
Signature of Physician, Physician Assistant, or Advanced Practice Registered Nurse