WICOMICO COUNTY DEPARTMENT OF RECREATION & PARKS

Summer Medical Packet

Instructions: Please have the documents that pertain to your child completed by your child's doctor.

Please contact the program director with any questions at 410.548.4900 X109 or at bbelfield@wicomicocounty.org.

MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

This form must be completed fully in order for youth camp operators and staff members to administer the required medication or for the camper to self-administer medication. A new medication administration form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An authorized individual must bring the medication to the camp and give the medication to an adult staff member.**

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME	2. DATE OF BIRTH ___/___/___ (Month / Day / Year)
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:	4. EMERGENCY MEDICATION [ ] YES *-If yes, see Section III below.* [ ] NO
5. MEDICATION NAME / 6. DOSE	7. ROUTE
8. TIME/FREQUENCY OF ADMINISTRATION	9. IF PRN, FREQUENCY
10. IF PRN, FOR WHAT SYMPTOMS	
11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD	
12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR.***	12a. FROM ___/___/___ (Month / Day / Year) / 12b. TO ___/___/___ (Month / Day / Year)
13. PRESCRIBER'S NAME/TITLE	This space may be used for the Prescriber's Address Stamp
TELEPHONE / FAX	
ADDRESS	
CITY / STATE / ZIPCODE	
14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	14b. DATE

II. PARENT/GUARDIAN 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 certify 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, as listed in 15c below, which may include the child, 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.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15C. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the youth camp operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE

MEDICATION ADMINISTRATION FORM
for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			DATE
PLAN OF ACTION RECEIVED [ ] YES [ ] NO [ ] N/A		HEALTH SUPERVISOR NOTIFIED [ ] YES [ ] NO	
MEDICATION RECEIVED BY	PERSON'S SIGNATURE		DATE

II. MEDICATION ADMINISTRATION RECORD

Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.

Child's Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION

KEEP FOR 3 YEARS

MDH-4759 (01/2017)

MEDICATION FINAL DISPOSITION FORM
for Youth Camps in Maryland

Maryland Department of Health (MDH)
Center for Healthy Homes and Community Services (CHHCS)
(410) 767-8417 Toll Free 1-877-4MD-MDH ext. 8417

I. FINAL DISPOSITION OF MEDICATION	
Child's Name:	**Date of Birth:**
Medication Name:	**Final Disposition:** [ ] **Returned** *(Complete Section A)* [ ] **Destroyed** *(Complete Section B)*
Section A	
MEDICATION RETURNED TO (NAME)	**DATE**
MEDICATION RETURNED BY (PERSON'S SIGNATURE)	**DATE**
Section B	
The above indicated medication was not retrieved by the parent/guardian or authorized individual within 1 week of the camper leaving camp; therefore, it has been destroyed according to COMAR 10.16.07.14.	
SIGNATURE OF PERSON RESPONSIBLE FOR DESTROYING MEDICATION	**DATE**
SIGNATURE OF PERSON WITNESSING THE DESTRUCTION OF THE MEDICATION	**DATE**

KEEP FOR 3 YEARS

Child Care Diabetes Medical Management Plan

American Diabetes Association.
YOUR RIGHTS. ONE VOICE.™

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature: _____ Date: _____

Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: ☐ 80-180 ☐ Other _____

When to check blood glucose: ☐ before breakfast ☐ before lunch ☐ before dinner ☐ before snacks

When to do extra blood glucose checks: ☐ before exercise ☐ after exercise ☐ when showing signs of low blood glucose ☐ when showing signs of high blood glucose ☐ other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

☐ Insulin Pump ☐ Multiple Daily Injections ☐ Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): ☐ Regular ☐ Apidra ☐ Humalog ☐ Novolog ☐ NPH ☐ Lantus ☐ Levemir ☐ Mix ☐ Other _____

Plan A: Insulin Pump*

1. Always use the insulin pump bolus wizard: ☐ Yes ☐ No
   If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
2. Blood glucose must be checked before the child eats and will (check one):
   ☐ Be sent to the pump by the meter
   ☐ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
4. **After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

1. Child will receive a fixed dose of _____ long-acting insulin at _____ ☐ **Yes** ☐ **No**
2. Follow blood glucose monitoring plan above.
3. **Use _____ insulin for meals and snacks. Insulin dose for food is** _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.

Give injection after the child eats.

4. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or this scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

1. Child will receive a fixed dose of long acting insulin? ☐ **Yes** ☐ **No**
   If yes, give child _____ units of _____ insulin at _____.
2. Insulin correction dose at child care (_____ insulin)?
   ☐ Yes ☐ No
3. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or the following scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

☐ Shaky ☐ Fast heartbeat ☐ Sweating
☐ Anxious ☐ Hungry ☐ Weakness/Fatigue
☐ Headache ☐ Blurry vision ☐ Irritable/Grouchy
☐ Dizzy ☐ Other _____

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
   - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

☐ Extreme thirst ☐ Very wet diapers, accidents
☐ Hungry ☐ Warm, dry, flushed skin ☐ Tired or drowsy
☐ Headache ☐ Blurry vision ☐ Vomiting**
☐ Fruity breath ☐ Rapid, shallow breathing
☐ Abdominal pain ☐ Unsteady walk (more than typical)

**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
   ☐ urine ☐ blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parent if ketones are trace or small: ☐ Yes ☐ No
3. Children with high blood glucose will require additional insulin **if the last dose of insulin was given 3 or more hours earlier**. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
   ☐ Provide carbohydrate free snacks if hungry
   ☐ Delay exercise
   ☐ Change diapers frequently/give frequent access to the bathroom
   ☐ Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction Factor – The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor**.

Diabetic Ketoacidosis (DKA) – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed dose regimen – Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct **hyperglycemia**.

Glucagon – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using and insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA)**.

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin Pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple Daily Injection Regimen - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 Diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

_____
Physician Signature

Safe at School

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
Seizure Medication Administration Authorization Form

Name of Child Care Facility _____

This form authorizes emergency seizure care for _____ ☐ M ☐ F
(Child's Name) (Date of Birth)
while attending the above named child care facility during child care hours. This form must be completed by the child's physician and signed by both physician and parent.

Treating Physician _____ Phone#_____ # After Hours_____

Significant Medical History: _____

Seizure Care Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Seizure Emergency Protocol (Check all that apply and clarify below)

☐ Call 911 for transport to _____ ☐ Notify parent or emergency contact

☐ Notify treating physician _____ ☐ Other_____

☐ Administer emergency medications as indicated below:

Emergency Medication	Dosage	Time	Route/method	Side Effects	Special Instructions

Does child need to leave the classroom after a seizure? ☐ **Yes** ☐ **No** If YES, describe process for returning the child to the classroom. _____

Special Considerations and Precautions (regarding activities, sports, trips, etc.) _____

_____

Physician Signature: _____ **Date:** _____

Parent Information & Authorization: Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects. I agree to review special instruction and demonstrate the medication administration procedure to the child care provider. I understand the risk and authorize for administration of emergency seizure medication to my child.

Parent/Guardian Signature: _____ **Date:** _____

Allergy Action Plan
Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

CHILD'S NAME: _____ Date of Birth: _____

ALLERGY TO: _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT

Symptoms: The child has ingested a food allergen or exposed to an allergy trigger:	**Give this Medication** Epinephrine	Antihistamine
But is ***not*** exhibiting or complaining of any symptoms		
Mouth: itching, tingling, swelling of lips, tongue or mouth ("mouth feels funny")		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat*: difficulty swallowing ("choking feeling"), hoarseness, hacking cough		
Lung*: shortness of breath, repetitive coughing, wheezing		
Heart*: weak or fast pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progressing (several of the above areas affected)		

*Potentially life-threatening. The severity of symptoms can quickly change.
*IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

Medication		**Dose:**
Epinephrine:		
Antihistamine:		
Other:		

_____ _____
Doctor's Signature Date

EMERGENCY CALLS

1) Call 911 (or Rescue Squad) whenever Epinephrine has been administered. 2) Call the parent. State that an allergic reaction has been treated and additional epinephrine may be needed. 3) Stay with the child.

Doctor's Name:_____ Phone Number:_____

Contact(s)	Name/Relationship	Phone Number(s) Daytime Number	Cell
Parent/Guardian 1			
Parent/Guardian 2			
Emergency 1			
Emergency 2			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE AND CALL 911.

Health Care Provider and Parent Authorization for Self/Carry Self Administration
I authorize the child care provider to administer the above medications as indicated. Students may self carry/self administer [school-aged only] ☐ yes ☐ No

_____ _____
Parent/Guardian's Signature Date

Allergy Action Plan
(Continued)

Must be accompanied by a Medication Authorization Form (OCC 1216)

Place Child's Picture Here

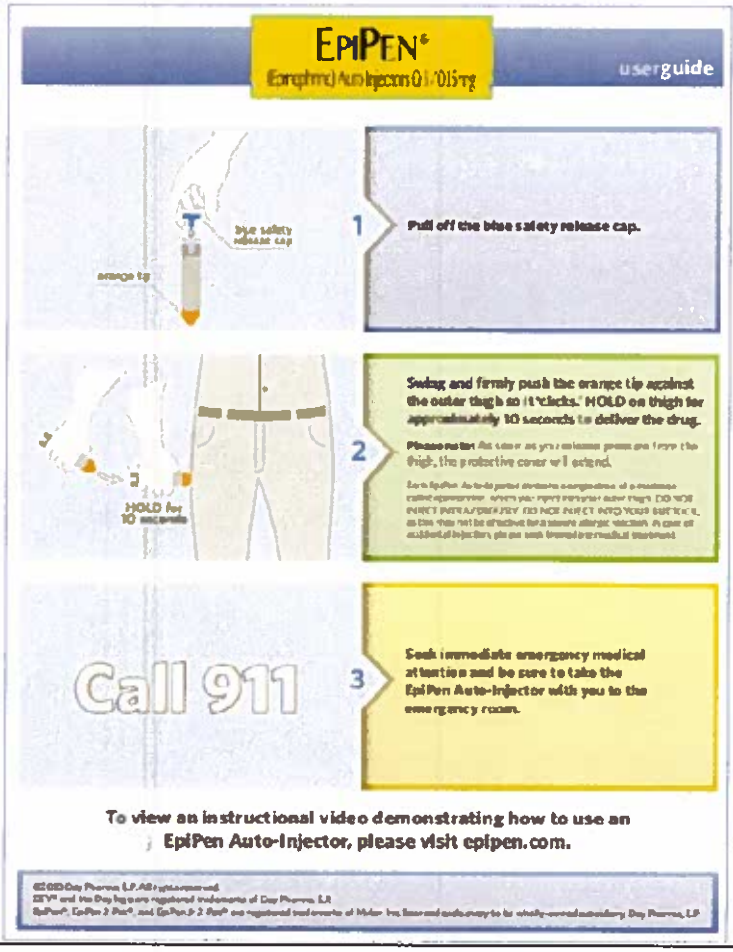
CHILD'S NAME _____ **Date of Birth** _____

ALLERGY TO _____

Is the child Asthmatic? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

The Child Care Facility will:

- ☐ Reduce exposure to allergen(s) by: (no sharing food,
- ☐ Ensure proper hand washing procedures are followed.
- ☐ Observe and monitor child for any signs of allergic reaction(s).
- ☐ Ensure that medication is immediately available to administer in case of an allergic reaction (in the classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies child on any off-site activity.
- ☐



The Parent/Guardian will:

- ☐ Ensure the child care facility has a sufficient supply of emergency medication.
- ☐ Replace medication prior to the expiration date
- ☐ Monitor any foods served by the child care facility, make substitutions or arrangements with the facility, if needed.
- ☐

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete both pages of this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

1. CHILD'S NAME (First Middle Last)	2. DATE OF BIRTH (mm/dd/yyyy) ___/___/_____	3. PEAK FLOW PERSONAL BEST:

4. ASTHMA SEVERITY (check one): ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

5. ASTHMA TRIGGERS (check all that apply): ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other_____

Section I. ASTHMA ACTION PLAN

6. THIS ASTHMA ACTION PLAN SHALL BE EFFECTIVE FOR AND MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 9b below unless more restrictive dates are specified in 6a and 6b. This authorization is NOT TO EXCEED 1 YEAR.	6a. FROM (mm/dd/yyyy) ___/___/_____	6b. TO (mm/dd/yyyy) ___/___/_____

GREEN ZONE - DOING WELL

You have **ALL** of these
- Breathing is good
- No cough or wheeze
- Can walk, exercise, & play
- Can sleep all night
- If known, peak flow greater than _____ (80% personal best)

Medication Name	Dose	Route	Frequency	OK to Self-Administer
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			
				☐ Yes ☐ No
	Known side effects:			

Exercise Zone

Rescue Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

☐ Prior to all exercise/sports
☐ When the child feels they need it

YELLOW ZONE - GETTING WORSE

You have **ANY** of these
- Some problems breathing
- Wheezing, noisy breathing
- Tight chest
- Cough or cold symptoms
- Shortness of breath
- Other:_____
- If known, peak flow between ____ and _____ (50% to 79% personal best)

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

RED ZONE - MEDICAL ALERT/DANGER

You have **ANY** of these
- Breathing hard and fast
- Lips or fingernails are blue
- Trouble walking or talking
- Medicine is not helping (15-20 mins?)
- Other:_____
- If known, peak flow below _____ (0% to 49% personal best)

Emergency Medication	Dose	Route	Frequency	OK to Self-Administer	OK to Self-Carry
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				
				☐ Yes ☐ No	☐ Yes ☐ No
	Known side effects:				

ASTHMA ACTION PLAN AND MEDICATION ADMINISTRATION AUTHORIZATION FORM

for Youth Camps in Maryland

Please complete this form if the child has an inhaler or other asthma-related medication

Maryland Department of Health (MDH)
Office of Healthy Homes and Communities
(410) 767-8417 or 1-877-4MD-DHMH ext. 8417

10

CHILD'S NAME (First Middle Last)	DATE OF BIRTH (mm/dd/yyyy) ___/___/_____

Section II. PRESCRIBER'S AUTHORIZATION

8. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIP CODE	

9a. PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only)	9b. DATE (mm/dd/yyyy)

Section III. PARENT/GUARDIAN AUTHORIZATION

I request the authorized youth camp operator, staff member or volunteer to administer the medication or to supervise the camper in self-administration as prescribed by the above authorized prescriber. I certify 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

10a. PARENT/GUARDIAN SIGNATURE	10b. DATE (mm/dd/yyyy)	10c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
10d. HOME PHONE #	10e. CELL PHONE #	10f. WORK PHONE #

Section IV. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

THIS SECTION SHOULD ONLY BE COMPLETED IF ANY MEDICATIONS IN THE ASTHMA ACTION PLAN ABOVE ARE APPROVED FOR SELF-ADMINISTRATION. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, youth camp operators are not required to permit self-administration or self-carry.

I authorize self-administration of all of the medications listed in *Section I: Asthma Action Plan* 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: Asthma Action Plan*, the child named above may self-carry emergency medications checked as "OK to self-administer and self-carry."

11a. PRESCRIBER'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	11b. DATE (mm/dd/yyyy)
12a. PARENT/GUARDIAN'S SIGNATURE FOR SELF-ADMINISTRATION/SELF-CARRY	12b. DATE (mm/dd/yyyy)

Section V. CAMP MEDICAL STAFF USE ONLY

Camp Medical Staff Notes:	
Reviewed by:	DATE (mm/dd/yyyy)