Barton Day Camp Session: ___Rainbow ___ Long Island 1 ___Long Island 2 ___Worcester ___Danvers

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER
THE BARTON CENTER FOR DIABETES EDUCATION, INC.

To be completed by Parent/Guardian:
Name of Camper: _____ Date of Birth ____/_____/_____ Age: _____
Parent/Guardian Name: _____
Home Tel.: _____Work Tel.: _____Cell: _____
Emergency Contact: _____ Tel.: _____

Parent/Guardian Authorization:
I request that the medication below be administered to my child as described and directed.
Parent Initials _____

Name of Camp: The Barton Center for Diabetes Education, Inc. Date: _____
Child's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:
First Name: _____ Last Name: _____
Relationship to Child: ☐ Mother ☐ Father ☐Guardian/Other explain: _____
Name of Camp Personnel Receiving Written Authorization and Medication: _____
Title/Position _____ Signature (in ink): _____

This Section MUST be Completed by an Authorized Provider:
Diabetes Medication:
Insulin (brand, types) _____
☐Injection ☐Insulin Pump If, Insulin pump (brand) _____
List current insulin to carb ratios and/or check (see attached sliding scale) for insulin dosages to be given at camp:
Short-acting Dose:
Breakfast _____ Snack _____ Lunch _____ Snack _____ Supper _____ Bed _____
Long-acting Insulin Dose:
Breakfast _____ Snack _____ Lunch _____ Snack _____ Supper _____ Bed _____
See Attached Sliding Scale ☐
Does the child self administer insulin? ☐Yes ☐No

Other Medications to be given at camp:
Name of Medication: _____
Dose given at camp: _____ Route of Administration: _____
Frequency: _____ Date Ordered: _____Duration of Order: _____ Quantity Received: _____
Expiration date of Medications Received: _____Special Storage Requirements: _____
Specific Directions (e.g., on empty stomach/with water):_____
Specific Precautions: _____
Possible Side Effects/Adverse Reactions: _____
Other medications (at parents' discretion): _____
Location where medication administration will occur: _____
Known Food/Drug Allergies: _____
Reactions: _____

********Authorized Provider's Signature Required**
Authorized Provider's Name: _____ Telephone: _____
Authorized Provider's Address: _____
City: _____ State: _____ Zip: _____
Authorized Provider's Signature: _____

Authorization to Administer Medication to a Camper (2)

I hereby authorize The Barton Center for Diabetes Education, Inc. to administer, to my child, _____the medication(s) listed above, in accordance with 105 CMR 430.160. (NAME OF CHIILD)

Connecticut:

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/Guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be kept in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

Massachusetts:

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.

Parent/Guardian Signature: _____

Date: _____