

Barton Day Camp Session: ___ Danvers ___ Worcester ___ Long Island

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

Please complete a separate form for each medication to be administered to camper **including insulin and glucagon.**

To be completed by Parent/Guardian:

Name of Camper: _____ Date of Birth ____/____/____ Age: _____

Parent/Guardian Name: _____

Home Tel.: _____ Work Tel.: _____ Cell: _____

Emergency Contact: _____ Tel.: _____

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/Licensed Provider:

Diabetes Medication:

Rapid-Acting Insulin (circle one): Humalog Novolog Apidra Fiasp Admelog Other: _____

Injection Insulin Pump If, Insulin pump (brand) _____

List current ratios, factors and targets and/or check "see attached order" for insulin dosages to be given at camp:

	Breakfast	Snack	Lunch	Snack	Supper	Bedtime	Overnight
Carb Ratio							
Correction							
Target							

Long-acting Insulin (circle one): Basaglar Lantus Levemir Tresiba Toujeo Other: _____

Time Given: _____ AM/PM Dose: _____ units

Time Given: _____ AM/PM Dose: _____ units

See Attached Orders

Other Medications to be given at camp:

Name of Medication (Prescribed or over the counter): _____

Diagnosis: (at parent/guardian's discretion) _____

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: _____ Business Tele.: _____

Authorized Provider's Address: _____

City: _____ State: _____ Zip: _____ Emergency Telephone: _____

Authorized Provider's Signature: _____

Parent/Guardian Authorization:

I hereby authorize The Barton Center for Diabetes Education, Inc. to administer to my child, _____
the medication(s) listed above, in accordance with M.G.L. c.94C, §7 (Name of Child)

If the listed medication includes epinephrine injection system:

I hereby authorize my child to self-administer, with approval of the health care consultant. ___Yes ___No ___Not applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer.
___Yes ___No ___Not applicable

If the above listed medication includes insulin:

I hereby authorize my child to self-administer, with approval of the health care consultant and supervision of health care supervisor. Yes No Not applicable

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

DANVERS AND WORCESTER DAY CAMP PARENTS/GUARDIANS: Please initial below where indicated.

Connecticut and New York:

In Connecticut and New York, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations and NY State Statutes and Regulations respectively. 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. (M.G.L. c. 94C, §21). **PLEASE INITIAL HERE: _____**

Specialty Camp Medication Administration – Massachusetts

Notwithstanding any general or special law to the contrary, the department of public health, pursuant to its authority under subsection (g) of section 7 of chapter 94C of the General Laws, shall promulgate regulations to allow: (i) student nurses and recently graduated student nurses, as included in the definition of "nurse" in section 1 of said chapter 94C; (ii) medical specialty camp staff trained under the supervision of a practitioner as defined in section 1 of said chapter 94C; and (iii) certified diabetes care and education specialists in good standing with the Certification Board for Diabetes Education and Care, to administer medication to campers at medical specialty camps as defined in the state sanitary code. **PLEASE INITIAL HERE: _____**

105 CMR 430.160(D)

A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:

- (1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.*
- (2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.*
- (3) Document the circumstances in which a camper, health care supervisor, or other employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:

 - (a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:

 - 1. the camper is capable of self-administration; and*
 - 2. the health care consultant and camper's parent/guardian have given written approval**
 - (b) Receive an epinephrine auto-injection by someone other than the health care consultant or Person who may give injections within their scope of practice if:

 - 1. the health care consultant and camper's parent/guardian have given written approval; and*
 - 2. the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.***
- (4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.* **PLEASE INITIAL HERE: _____**