Teens To Go™, Inc.
14 Flints Grove Dr.
Gaithersburg, MD 20878

WWW.TeensToGo.Org
Office: (301) 540-4356
Fax: (888) 566-9693

Teens To Go Medication Form

If your child will be taking medication during the camp operating hours, the attached State of Maryland Medication form MUST be filled out completely by the parent and the prescriber of the medication. Furthermore, all of the directions MUST be followed (listed in the first box). If your camper will be going for more than 1 session, only 1 form needs to be filled out.

This form must be completed if:

- You would like the Teens To Go Staff to hold on to the medication
- The camper will hold on to the medication
- "Incident-Only" medication (inhalers, allergy, headaches, . . .)
- Over the counter medication (Tylenol, motion sickness, . . .)
  Please note – we CANNOT give out motion sickness medication unless YOU provide it

Directions:

- Fill out the form completely (a separate form for each medication).
- BRING the form on the first day of camp – Please DO NOT send it in prior.
- Make sure to bring the medication in its ORIGINAL container. We CANNOT accept the medication in plastic bags, pill boxes, or any other container.

The unused medication and/or container will be returned to you at the end of the session.

We appreciate your time and effort in this matter. If you have any questions, please let us know (301) 540-4356.

We look forward to a great summer with your camper.

Sincerely,

Manish Shah
Director, Teens To Go, Inc.

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Department of Health & Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301
Baltimore, Maryland 21202-1608
(410) 767-8417 FAX (410) 333-8926
Toll Free 1-877-4MD-DHMH ext. 8417

I. CAMP OPERATOR

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 adult must bring the medication to the camp and give the medication to an adult staff member.**

II. CAMP INFORMATION

YOUTH CAMP NAME Teens To Go

PHYSICAL ADDRESS 14 Flints Grove Dr.

CITY Gaithersburg STATE MD ZIPCODE 20878

III. PRESCRIBER'S AUTHORIZATION

CHILD'S NAME		DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE	ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY	
IF PRN, FOR WHAT SYMPTOMS		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD		
MEDICATION SHALL BE ADMINISTERED *(NOT TO EXCEED 1 YEAR)*	FROM	TO

PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	
PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*		DATE	

IV. PARENT/GUARDIAN AUTHORIZATION

I request authorized youth camp operator/staff to administer the medication as prescribed by the above 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 adult must pick up the medication, otherwise it will be discarded. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending camp.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

V. AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE

DHMH #