Bay State Elite Soccer Academy

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (To be completed by parent/guardian)

Name of Camper: _____ Age: _____
Parent/Guardian Name: _____
Food/Drug Allergies: _____
Home Telephone: _____
Diagnosis (at parent's discretion): _____
Business Telephone: _____
Emergency Telephone: _____
Name of Licensed Prescriber: _____
Business Telephone: _____
Emergency Telephone: _____
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): _____
_____
_____

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Authorization to Administer Medication to a Camper (2)

I hereby authorize (NAME OF CAMP) _____ to administer, to my child, (NAME OF CHIILD) _____ _the medication(s) listed above, in accordance with 105 CMR 430.160.

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 of 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: _____

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Camper's Name: _____Date of Birth: _____
Address: _____
Phone #:_____ Email: _____
Gender: ____ Age: ____
Parent's Names and Phone Number during Camp Hours
Mother: _____Phone: _____ Father: _____ Phone: _____
Emergency Contact:_____ Phone: _____

Health History: (Circle any that apply)

Heart Problems	Hay Fever	Earaches	German Measles
Asthma	Sinus Problems	Whooping Cough	Measles
Chickenpox	Bee Sting Allergy	Diabetes	Mumps
Drug Allergy	Seizures	Ivy, Oak Allergies	Glasses Contacts

Food Allergy (specify) _____
Detail any of the above: _____
Medication being taken (name and explain): _____
Operations, injuries, special restrictions (give dates): _____

REQUIRED IMMUNIZATIONS - list month and year
D.T.P. (4 doses) _____ _____ _____ _____
Polio (3 doses) _____ _____ _____
Hepatitis B (3 doses) _____ _____ _____
M.M.R. (2 doses) _____ _____
TD booster (1 dose while in Grades 7-12) _____
Varicella Vaccine or proof of disease _____
Date of last physical examination (must be within last 12 months): _____

I certify that the above medical information is complete and accurate.
Physician Signature: _____Print Name: _____
Address: _____Phone: _____

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CONSENT FOR MEDICAL TREATMENT FOR A MINOR (one form per child) As parent or legal guardian of I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or the well-being of my dependent. “I understand that the directors and coaches of Elite 8 Soccer Academy or anyone associated with the sites we run our camps at, its trustee, agents and officers, will not assume responsibility for accidents and medical or dental expenses incurred as a result of participation in this program. The applicant is covered by our family insurance, is in good health, and able to participate in the physical activity of a vigorous program. I hereby authorize the camp directors to act for me accordingly to their best judgment in any emergency requiring medical attention. I will hold harmless Elite 8 Soccer Academy, and any other site used by Elite 8 Soccer Academy, it’s trustees, agents and officers of any and all liability actions, causes of action, claims and demands of every kind and nature whatsoever which may arise in connection either with or resulting from participation in any of its activities.”

Parent or Guardian Signature: _____Date: _____

Family Health Insurance Company and Policy#: _____