Bay State Elite Soccer Academy

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER
(to be completed by Parent/Guardian)

Name of Camper

Date of Birth / / Age of Camper

Food/Drug Allergies

Parent/Guardian Name

Diagnosis *(at parent's discretion)*

Telephone; *Home* - -

Business - -

Emergency - -

Name of Licensed Prescriber

Telephone; *Business* - -

Emergency - -

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 parent's discretion)*

Bay State Elite Soccer Academy

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (2)
(to be completed by Parent/Guardian)

I hereby authorize Bay State Elite Soccer Academy to administer, to my child, (NAME OF CHILD),

_____,

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 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 ☐☐ / ☐☐ / ☐☐☐☐

Bay State Elite Soccer Academy

Name of Camper _____ Gender _____

Date of Birth __/__/____ Age of Camper _____

Address _____

Phone ___-___-____ Email _____

Parents' Names and Phone Number during Camp Hours

Mother _____ Telephone ___-___-____

Father _____ Telephone ___-___-____

Emergency Contact _____ Telephone ___-___-____

Health History (please check 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 _____ Telephone ___-___-____

Bay State Elite Soccer Academy

CONSENT FOR MEDICAL TREATMENT FOR A MINOR (one form per child) As parent or legal guardian of (NAME OF CHILD) _____,

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 Bay State Elite Soccer Academy or anyone associated with the sites we run our camps at, its trustees, 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 according to their best judgment in any emergency requiring medical attention. I will hold harmless Bay State Elite Soccer Academy, and any other site used by Bay State Elite Soccer Academy, its 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 _____

_____