MEDICATION ADMINISTRATION FORM

for Youth Camps in Maryland

Maryland Department of Health (MDH) Center for Recreation and Community Environmental Health Services (CRCEHS)

Office (410) 767-8417 Toll Free 1-877-463-3464 ext. 78417

I. FACILITY RECEIPT AND REVIEW											
MEDICAT	ION RECE	IVED FROM						DATE			
PLAN OF	ACTION F	RECEIVED	[]YES	[]NO	[] N/A	HEALTH SUPERV	ISOF	R NOTIFIED	[]YES	[] NO	
MEDICAT	TON RECE	EIVED BY	PERSON'S SIGNATURE						DATE		
II. MEDICATION ADMINISTRATION RECORD											
Each administration of the listed medication shall be noted on the child's record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.											
Child's Name:						Date of Birth:					
Medication Name:						Dosage:					
Route:						Time(s) to Administer:					
DATE	TIME	DOSAGE	REACTION	OBSERV	ED (IF ANY)				IVIDUAL WHO ADMINISTERED ISED SELF-ADMINISTRATION		

KEEP FOR 3 YEARS

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