

# Health Care Consultant Acknowledgement of On-Site Medications

## Health Care Consultant Information

Name, Title and License #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Agreement Information

I, \_\_\_\_\_, acknowledge that I serve as the Health  
(Print Name)

Care Consultant for \_\_\_\_\_  
(Camp Name)

As such, I hereby authorize the following **listed medications** to be administered to campers as prescribed, provided that, the medications are delivered to the camp, maintained by the camp, and administered in accordance with Commonwealth of Massachusetts Regulations at 105 CMR 430.160 and that the parent/guardian of the camper has provided written permission for the administration of the medication.

I am not the prescribing physician for these medications. My signature indicates only that I have reviewed the listed medications and associated potential side effects, adverse reactions and other pertinent information with all personnel listed below, who administer medications or designated health care supervisors who are appropriately trained to and are doing so under my professional oversight.

**Names of individual/s authorized to administer medications at camp:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Signature of Health Care Consultant

Signature: \_\_\_\_\_

Date: \_\_\_\_\_