# Sample Health Care Consultant

# Acknowledgement of On-Site Medications

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| Health Care Consultant Information | | | |
| Name: | | | |
| MA License Number: | | | |
| Type of Medical License:    Physician Physician Assistant Nurse Practitioner | | | |
| Address | | | |
| City: | State: | | Zip Code: |
| Additional Contact Information | | | |
| Phone: | | Fax: | |
| Email: | | | |

## Agreement Information

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I serve as the Health  (Print Name)  Care Consultant for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  (Camp Name)  As such, I hereby authorize the **list of attached** 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 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 attached list of 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.  Name(s) of individual authorized to administer medications at camp:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Signature of Health Care Consultant

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| --- | --- | --- | --- |
| Signature: |  |  |  |
|  |  |  |  |

Date:

|  |  |  |  |
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Below are the prescription medications reviewed by the Health Care Consultant to be administered at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by individuals authorized to administer medications at camp.

(Camp Name)

|  |  |
| --- | --- |
|  | **Name of Medication(s)** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |
| **6.** |  |
| **7.** |  |
| **8.** |  |
| **9.** |  |
| **10.** |  |
| **11.** |  |
| **12.** |  |
| **13.** |  |
| **14.** |  |
| **15.** |  |
| **16.** |  |
| **17.** |  |
| **18.** |  |
| **19.** |  |
| **20.** |  |

**\*Please use multiple copies of this page if additional medications are administered at camp.**