Authorization for the Administration of Medication

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/Guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. ***Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. Undocumented or improperly-labeled medication WILL NOT be accepted***. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

Authorized Prescriber's Order (Physician, Dentist, Physician's Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____Today's Date ____/____/____
Address _____ Town _____
State _____ Zip_____ Phone Number (_____) _____
Medication Name _____ Controlled Drug? YES NO
Dosage _____ Method _____ Time of Administration _____
Specific Instructions for Medication Administration _____
Medication Administration: Start Date _____/_____/_____ Stop Date _____/_____/_____
Is this medication to be self-administered by the child? Yes No
Relevant Side Effects of Medication _____
Plan of Management for Side Effects _____
Known Food or Drug Allergies? YES NO Reactions to? YES NO Interactions with? YES NO
If "yes" to any of the above, please explain _____
_____
********** DOCTOR SIGNATURE REQUIRED BELOW **********

Prescriber's Name_____ Phone Number (_____) _____
Prescriber's Address _____Town _____
Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

First Name _____ Last Name _____

Relationship to Child: Mother Father Guardian Other - explain: _____

Signature of Parent/Guardian Authorizing Administration of Medication_____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position_____ Signature (in ink) _____