AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date___/___/___

Name of Child____ Date of Birth ___/___/___

Street Address ________________________________City/Town______________State______

Condition for which drug is being administered during camp hours_______________________
____

DRUG: Name of Drug, Dose and Method of Administration ____________________________
____

Times of Administration: __, __, __Medication shall be administered from __/__/__- __/__/___

Relevant side effects to be observed, if any ____
____

If there are side effects, plan for management ____
____

Is this a controlled drug? ____

Allergies, reaction to, or negative interaction with food or drugs? If YES, list _______________
____

The authorized prescriber's or Dentist's Name ______________________Phone # (___) ______
(type or print)

Street Address _________________________________City/Town_______________State_____

Authorized Prescriber or Dentist's Signature ____

Authorization by Parent/Guardian for the administration of the above medication: Date: __/__/__

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child _____________________, be administered by the camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian ____________________________Signature _____________________
(Print Name)

Relationship to child ________________________Street Address ___________________________

City/Town _________________State ______________Zip Code ________ Phone (___) _______

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

Please Return Completed Form To Parks & Recreation Office

☐ Camper
☐ Staff
Name______________________ Date of Birth_______________ Phone____________
Guardian____________________Address___________________________________
Emergency Contact_____________________________________ Phone____________
Date of Arrival at Camp:_________________________ Departure Date_____________

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTIONER:

Date of Exam___________

_____May participate in all camp activities
____May participate except for:____
____

Medical information pertinent to routine care and emergencies:_____________________
____

Is this individual taking prescription medication? ☐ YES ☐ NO
If yes, indicate prescription:____

Does the individual have allergies? ☐ YES ☐ NO Explain:____________
Is the individual on a special diet? ☐ YES ☐ NO Explain:____________

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:____
____
____

Print name of medical care provider:_______________________________
Medical care provider's address:___________________________________
Medical care provider's: City/Town____________________ST_____________Zip Code_________

____
Signature of Physician, APRN or AP

____
Date Form Signed

____
Telephone Number