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 (___) _______