AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

In Connecticut, licensed camps administering medication to children shall comply with all requirements regarding the Administration of Medications described in the Connecticut 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 the child's name, name of medication, original prescription, directions for medication's administration, and date of the prescription.** All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

Parent/Guardian Authorization:

I have read, understood, and accepted the information regarding my child's medication.
_____ I request that medication be administered to my child as directed.
_____ I request that medication be self-administered to my child as directed.

Name of Parent/Guardian Authorizing Administration of Medication as described and directed:
First Name:_____ Last Name:_____
Address:_____ Phone Number:_____
Signature of Parent/Guardian Authorizing Administration of Medication:_____
Today's Date: _____

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

Name of Child:_____ Date of Birth:_____ Today's Date:_____
Medication Name:_____ Controlled Drug? Yes___ No___
Condition for which drug is being administered:_____
Dosage:_____ Method/Route:_____
Time of Administration:_____ If PRN, frequency:_____
Medication shall be administered: Start Date:_____ End Date:_____
Specific instructions for Medication Administration: _____
Is this medication to be Self-Administered by the child? Yes___ No____
Relevant Side Effects of Medication:_____ None Expected____
Plan of Management of Side Effects: _____
Food or Drug Allergies? Yes__ No__ Reactions to? Yes__ No__ Interactions with? Yes__ No__
If "yes" to any of the above, please explain:_____
Prescriber's Name:_____ Phone Number:_____
Prescriber's Address:_____ Town:_____
Prescriber's Signature:_____ Date:_____

Internal use only:
*Camp or First Aid Director Signature:*_____ *Date:*_____
*Camp Instructor Signature:*_____ *Date:*_____