

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY YOUTH CAMP PERSONNEL FOR CAMPS AWOSTING AND CHINQUEKA

If a Youth Camp chooses to administer prescription 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. Prescription medication 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 medications 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 _____

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? _____ Yes _____ No Is this drug self-administered? _____ Yes _____ No

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

Authorized Prescriber's or Dentist's Name _____ Phone # (____) _____ - _____

(Print or Type)
Street Address _____ City/Town _____ State _____

Authorized Prescriber or Dentist's Signature _____ Date ____/____/____

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 nurse or by camp personnel with current Medical 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 medications 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/Guardian _____ Signature _____

Relationship to child _____ Street Address _____

City/Town _____ State _____ Zip Code _____ Phone (____) _____ - _____

THIS FORM MUST BE COMPLETED FOR EVERY PRESCRIPTION MEDICATION AND DAILY OVER-THE-COUNTER MEDICATION REQUIRED BY A PHYSICIAN. A SEPARATE FORM IS REQUIRED FOR EACH MEDICATION.

