

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS
BY YOUTH CAMP PERSONNEL**

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 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 ____ / ____ / ____ to ____ / ____ / ____

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 prescribers' 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 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 (____) _____