SoundWaters
DISCOVER THE SOUND. EMBRACE THE WORLD.

Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT 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 child's name, name of medication, directions for medication's administration, and date of the prescription.

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

Name of Child_____ **Date of Birth**____/____/____ **Today's Date**____/____/____

Medication Name_____ **Controlled Drug?** ☐**YES** ☐**NO**

Dosage_____ **Method**_____ **Time of Administration** _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date_____/_____/_____ **Stop Date**_____/_____/_____

Is this medication to be self-administered by the child? ☐**YES** ☐**NO**

Relevant Side Effects of Medication_____ **Plan of Management for Side Effects**_____ **Known 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 & Stamp**_____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Camp_____ **Today's Date**_____/_____/____ **Child's Name**_____ **Address**_____ **Town**_____ **Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:** **First Name**_____ **Last Name**_____ **Relationship to Child:** ☐**Mother** ☐**Father** ☐**Guardian/Other explain:**_____ **Address**_____ **Town**_____ **Phone Number (**____**)**_____ **Signature of Parent/Guardian Authorizing Administration of Medication** _____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position_____ Signature (in ink) _____

A separate form is required for each medication