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