



# Authorization Form for 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 for 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, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following termination of the order, or following the last day of camp.

**AUTHORIZED PRESCRIBER'S ORDER (M.D., Dentist, P.A., A.P.R.N.):** Today's Date \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medication Name \_\_\_\_\_ Is this a controlled Drug? \_\_\_ Yes \_\_\_ No

Dosage \_\_\_\_\_ Method \_\_\_\_\_

Time(s) of administration \_\_\_\_\_ Start Date \_\_\_\_\_ Stop Date \_\_\_\_\_

Specific Instructions, if any \_\_\_\_\_

Is this medication to be self-administered by the child? \_\_\_ Yes \_\_\_ No

Relevant side effects of medication \_\_\_\_\_

Plan of management for side effects \_\_\_\_\_

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

Prescriber's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Prescriber's Full Address \_\_\_\_\_

**Prescriber's Signature** \_\_\_\_\_

## AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

Name of Camp: **Holiday Hill Day Camp** Today's Date \_\_\_\_\_

I hereby request that medication be administered to my child \_\_\_\_\_, as described and directed above.

Parent/Guardian Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Full Address (No., Street, Town, Zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_

Name of Camp Personnel Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature (in ink) \_\_\_\_\_