AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY YOUTH CAMP PERSONNEL FOR BOULDER RIDGE DAY CAMP

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.