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/DENTIST' S ORDER: Date: _____/_____/_____

Name of Child: ____ Date of Birth: _____/_____/____________

Mailing 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, reactions to, or negative interaction with food or drugs? If yes, list: __________________________________

____

Authorized Prescriber's/Dentist's Name: _________________________________ Phone: (_____)_____-_________

Mailing Address: ________________________________City/Town: _________________________State: _______

Authorized Prescriber/Dentist's Signature: ____ Date:___/____/_____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF 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: ___________________ Mailing 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.