Authorization for the Administration of Medication by Youth Camp Personnel

In Connecticut, licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child ________________________________ Date of Birth____/____/____ Today's Date____/____/____

Address of Child ____Town/State___________________

Medication Name/Generic Name of Drug____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: ____

Specific Instructions for Medication Administration ____

Dosage______________________________Method/Route_______________________________________

Time of Administration _________________________ If PRN, frequency______________________________

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/______

Relevant Side Effects of Medication ____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs____

Plan of Management for Side Effects ____

Prescriber's Name/Title ____ Phone Number (_____) ______________

Prescriber's Address ____ Town ___________________

Prescriber's Signature ____Date _____/_____/_____

Parent/Guardian Authorization

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

☐ I request the above ordered medication be administered by youth camp personnel. I give permission for the exchange of information between the prescriber and camp personnel necessary to ensure the safe administration of this medication.

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child without adverse effects.

Parent/Guardian Signature___________________________________ Date ____/____/____

Parent /Guardian's Address ____Town___________________State_____

Home Phone # (_____) ______-________ Work Phone # (_____) ______-________ Cell Phone # (_____) ______-_______

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the prescriber.

Prescriber's authorization for self-administration: YES NO ____
Signature Date

Parent/Guardian authorization for self-administration: YES NO ____
Signature Date

PLEASE NOTE YOU MUST HAVE ONE FORM FOR EACH PRESCRIPTION AND OVER-THE-COUNTER MEDICATION YOU SEND WITH YOUR CHILD. PLEASE MAKE AS COPIES OF THIS FORM AS NECESSARY.

Today's Date ___________ Printed Name of Individual receiving Written Authorization and Medication ______________________________________

Title/Position ______________________________ Signature ______________________________

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)