DPNC

☐ **Yes:** My child requires medication at camp (Fill out form, initial and return) _____

☐ **No**: My child does not require medication at camp (Leave form blank, initial and return) _____

(Must check one)

Reset This Form

Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medication 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 the child's name, name of the 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 the camper's departure at the end of camp.

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 Adminitration _____

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: _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described 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) _____