

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A. or 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. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the medication, strength, dosage, frequency, authorized prescriber or dentist's name and date or original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER:

Date of Order: _____

Name of Child: _____

Date of Birth: ___/___/___

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Condition for which the medication is being administered during camp hours: _____

Medication: Name of medication, dosage and method of administration: _____

Times of administration: _____ Medication shall be administered from: ___/___/___ through ___/___/___

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled medication? _____

Allergies, reaction to, or negative interaction with food and drugs? If yes, list: _____

AUTHORIZED PRESCRIBER'S OR DENTIST'S INFORMATION (PLEASE PRINT):

Authorized Prescriber's or Dentist's Name: _____ Telephone number: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Authorized Prescriber's or Dentist's Signature: _____ Date: _____

AUTHORIZATION BY PARENT/GUARDIAN FOR ADMINISTRATION OF ABOVE MEDICATION

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child, _____, be administered by the nurse or camp personnel with current Medication 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 the termination of the order.

Parent/Guardian Name: _____ Relationship to Camper: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Parent/Guardian Signature: _____ Date: _____ Emergency Phone Number: _____

SELF ADMINISTERED INHALER/EPIPEN OR MEDICATION FOR LIFE THREATENING ILLNESS

This is only for life threatening illnesses, not over the counter medications!

A camper may be permitted to self-administer a medication for a life threatening allergy or illness. The parent must understand that the camp will not accept any responsibility for injury arising from the self medication and sign the following statement to that effect. I hereby give permission for my child, _____, to self-administer _____, which is a medication required for the following medical condition _____. My child is capable of, and has been instructed in the proper administration of the required medication. I understand that the Randy Edsall Football Camp will not be held responsible for any injury arising from self-administration.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date: _____