



**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS  
BY CAMP PERSONNEL  
(ONE FORM PER MEDICATION TAKEN)**

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization (s) and the medications 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 medications administration and date of the prescription. All unused medication will be destroyed if not picked up within one week following camper's departure at the end of camp.

**AUTHORIZED PRESCRIBER 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 \_\_\_\_\_

Special Instructions for Medication Administration \_\_\_\_\_

Medication Administration: Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_. Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_.

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 # (\_\_\_\_) \_\_\_\_\_  
(Type or Print)

Prescriber's Address \_\_\_\_\_ City/Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION:**

I hereby request that Medication be administered to my child as described and directed above.

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 medication shall be in the original container labeled by the parent with the child's name.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent or Guardian Authorizing Administration of Medication \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian/Other explain \_\_\_\_\_  
(Print Name)

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

Name of Camp Personnel Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature \_\_\_\_\_

