



**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. 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 _____ **Self Administered?** 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 _____

Name of Prescriber _____ Phone # (____) _____

Address of Prescriber _____ (Type or Print) City/Town _____

Signature of Prescriber _____

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 New Heights Summer 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 _____