

# AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION



**PLEASE NOTE:** A separate form is required for each medication.

Connecticut State Law and Regulations require a written medication order by authorized prescriber, and parent/guardian written authorization for health center staff to administer medication. Medications must be in original, properly labeled container and dispensed by a prescribing provider/pharmacist.

*This form must be completed for ALL medications taken while at camp. This includes prescriptions, vitamins, supplements, daily allergy meds, and sleep aids. It is also required for any camp-stocked medication you have authorized if your child will be taking them on a daily basis.*

## PRESCRIBER'S AUTHORIZATION

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Route: \_\_\_\_\_ Time of Administration: \_\_\_\_\_

Camp dates medication shall be administered: from (MM/DD/YY): \_\_\_\_\_ to (MM/DD/YY): \_\_\_\_\_

### For EpiPens/Inhalers:

EpiPens and rescue inhalers are always available to campers through the Health Center, including during activities. If a camper needs to carry their EpiPen or inhaler with them at all times, please authorize below.

*Note: Campers who self-carry must also provide a second EpiPen or inhaler to be stored in the Health Center.*

Prescriber's permission to self-carry EpiPen or Inhaler:  Yes  No Prescriber's Initials: \_\_\_\_\_

### PRESCRIBER INFORMATION

or PRESCRIBER STAMP:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PARENT/GUARDIAN AUTHORIZATION

I hereby request that the medication above be administered to my child by camp Health Center personnel. I understand that I must provide camp with a supply of medication for the length of the camp enrollment. I will contact the Health Center with any changes to the above information or if questions or concerns arise at nurse@campmohawk.org. I understand that this medication will be destroyed if not picked up during check-out.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_