AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

the YMCA CAMP MOHAWK FOR GIRLS • EST 1920

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. Written authorization along with the medication must be received before we can administer any medication.

This form is REQUIRED for ALL medications including: prescriptions, vitamins, supplements, sleep aids, topical ointments, daily allergy medications (including those stocked by camp under standing orders).

PRESCRIBER'S AUTHORIZATION

Camper Name:_____ Date of Birth:_____

Primary Home Address:_____

Medication Name:_____ Controlled Drug? ☐ Yes ☐ No

Dosage:_____ Method:_____ Time of Administration:_____

Specific Instructions for Medication Administration:_____

Medication Administration Start Date (MM/DD/YY): _____ Stop Date (MM/DD/YY): _____

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:_____

SELF-CARRY/SELF-ADMINISTRATION (EpiPens & Inhalers Only):

EpiPens and rescue inhalers are always available to campers 24 hours a day. 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: _____

Parent/Guardian permission to self-carry EpiPen or Inhaler: ☐ Yes ☐ No Parent/Guardian 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 attest that I have administered at least one dose (except an EpiPen) without adverse effects. 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:_____ Relationship to Camper:_____

Parent/Guardian Signature:_____ Date:_____

Mohawk RN Receiving Med: _____ **Date:**_____ **Med Approved for CM:**_____ **Date:**_____