

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS
BY CAMP PERSONNEL**

ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINERS!

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aider, the director, alternate director or youth camp counselor to administer medications. **Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.**

PHYSICIAN OR DENTIST'S ORDER:

Date: ___/___/___

Name of Child: _____ Date of Birth ___/___/___

Street Address _____ City _____ State _____

Condition for which drug is being administered during camp hours _____

DRUG: Name of Drug, Dose and Method of Administration _____

Times of Administration: ____, ____ Medication shall be administered from ___/___/___ - ___/___/___

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Allergies to food or drug? If YES, list _____

Physician's/Dentist's Name _____ Phone # () _____

Street Address _____ City _____ State _____

Physician's/Dentist's Signature _____

AUTHORIZATION by Parent/Guardian for the administration of the above medication:

Date: ___/___/___

To nurse, first aider, director, alternate director or youth camp counselor:

I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by the nurse, first aider, director, alternate director or youth camp counselor.

I understand that I must supply the Basketball Factory with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication 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 termination of the order.

Do you give permission for your child to self administer his/her medication? YES NO

Name of Parent or Guardian _____ Signature _____

Relationship to child: _____ Phone () _____

Street Address _____ City _____ State _____