

YMCA Camp Mt. Laurel
AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A., APRN) or dentist's written order and the parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training 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, authorized prescriber or dentist's name and the date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date ___/___/___

Name of Child _____ Date of Birth _____

Street Address _____ City/Town _____ State _____

Condition for which drug is being administered during camp hours _____

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

Time 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, reaction to, or negative interaction with food or drugs? If YES, list _____

Authorized Prescriber or Dentist's Name: _____ Phone #: (____) _____

(Type or Print)

Street Address _____ City/Town _____ State _____

Authorized Prescriber or Dentist's Signature _____

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

Date: ___/___/___

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child, _____, be administered by the nurse or by camp personnel with current Medication Administration Training.

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.

I understand that this medication will be destroyed if it is not picked up within one (1) week following the termination of the order.

I give my child permission to self administer his/her prescribed inhaler or epipen as directed per the health care providers direction on the authorization of medication form. [] YES [] NO

Name of Parent or Guardian _____ Signature _____

Relationship to child _____ Street Address _____

City/Town _____ State _____ Zip Code _____ Phone (____) _____