

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS  
BY SUMMERSCAPE DAY CAMP PERSONNEL AND/OR A CAMPER**

In order for medications to be administered at camp, 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, youth camp counselor or camper 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/ Town Address \_\_\_\_\_ 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 drugs? If YES, list \_\_\_\_\_

Physician's/ Dentist's Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

(Type or Print)

Street Address \_\_\_\_\_ City/ Town \_\_\_\_\_ State \_\_\_\_\_

Physician or 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 Youth Camp 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.

Name of Parent or Guardian \_\_\_\_\_ Signature \_\_\_\_\_

(Print Name)

Relationship to child: \_\_\_\_\_

Street Address \_\_\_\_\_ City/ Town \_\_\_\_\_ State \_\_\_\_\_ Phone ( ) \_\_\_\_\_