New England Science & Sailing

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Authorized Prescriber's Order (Physician, Dentist, Physician's Assistant, Advanced Practice Registered Nurse):

Name of Child: _____ Date of Birth: _____ Today's Date: _____

Medication Name: _____ Controlled Drug? Yes ___No ___

Dosage: _____ Method: _____ Time of Administration: _____

Specific Instructions for Medication Administration: _____

Medication Administration: Start Date: _____ Stop Date: _____

Is this Medication to be Self-Administered by the child? Yes ___No ___

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: _____

Prescriber's Name: _____ Phone Number: (____) _____

Prescriber's Address: _____ Town: _____

Prescriber's Signature: _____

Parent/Guardian Authorization:

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered.

Medications must be in the original container and labeled with the child's name, name of medication, original prescription, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

I have read, understood, and accepted the above information regarding my child's medication: _____

_____ I request that medication be administered to my child as described and directed above

_____ I request that medication be self-administered to my child as described and directed above

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name: _____ Last Name: _____

Address: _____ Town: _____ Phone Number: (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication: _____

Today's Date: _____

Internal use only:
Camp Director Signature (In ink): _____ Date: _____